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**Drug problems and social exclusion:
The development of heroin careers in risk environments.**

**A thesis submitted to Middlesex University
in partial fulfilment of the requirements for the degree of
Doctor of Philosophy**

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Abstract

The location-specific drug scenes identified in Ireland and the UK in the 1980s indicated that problem drug use had a particular social and spatial focus in urban working-class communities, particularly those affected by unemployment and deprivation. This thesis explores localised drug problems in a number of disadvantaged neighbourhoods of Dublin by locating the perspective and experience of heroin users within the context of the social and economic contexts in which they live and operate. Taking a critical interpretivist methodological approach, the concepts of social exclusion and risk environments are used as heuristic devices for understanding the context in which problematic drug careers develop in marginalised areas. Using a multi-method research design, the study draws on secondary demographic, socio-economic and policy data to provide a contextual framework of risk environments. The study then explores the development of heroin careers and the lived experience of social exclusion through in-depth qualitative interviews with sixty-one heroin users and an ethnographic study of the five socially excluded Dublin neighbourhoods in which they lived. An inductive analysis of the themes arising from the data describes the interactive dynamics at play in which social and structural processes are seen to both facilitate, and be facilitated by, local drug problems. The multiple and interconnected risks that drug users are seen to encounter at both a micro and macro environmental level contributes to our knowledge of localised drug problems and their relationship with social exclusion, and leads to the development of the concept of a risk environment for drug problems with consequent potential for informing grounded policy interventions.

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*Aileen O'Gorman
Dublin
January 2005*

*Dedicated to my much missed parents
Michael and Caith O’Gorman
with love and respect*

Preface

Some of the themes and issues discussed in this thesis - relating to the methodology, fieldwork, and the drug situation in Ireland - have been previously published. The section on the 'Drug situation in Ireland' (in Chapter Two) is based on material which first appeared in O'Gorman, A. (1998) 'Illicit drug use in Ireland: an overview of the problem and policy responses', Journal of Drug Issues, 28, 1, p155-166. A discussion on using qualitative methods to explore the issues of drugs and social exclusion, based on the research undertaken for this doctorate, was published in a chapter titled 'Researching the social exclusion - problematic drug use nexus' in an EMCDDA¹ monograph edited by J. Fountain (2000) Understanding and responding to drug use: the role of qualitative research. Luxembourg: EC Official Publications, p137-142. In addition, some of the issues raised in the methodology chapter, relating to the fieldwork I conducted for this thesis, have been previously published in an article entitled 'From research design to execution: maintaining consistency and validity while responding to contingencies in the field' which appeared in the journal *Addiction Research & Theory*, 9, (6), p575-585, in 2001.

¹ EMCDDA - European Monitoring Centre for Drugs and Drug Addiction.

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Chapter One

Introduction

The community-based drug scenes which materialised in Ireland and the UK in the early 1980s, signified a qualitative shift in the pattern of illegal drug use in these countries (see Dorn and South, 1987). Prior to this, drug users and drug scenes tended to congregate in urban public spaces such as in London's Piccadilly area (as described by Burr, 1983), or be associated with the lifestyles of musicians, artists, and medical students (see Stimson, 1973). In contrast, the 'new heroin users' of the 1980s were seen to be socially and spatially clustered in urban working-class communities, particularly those affected by unemployment and deprivation.

The concentration of problematic drug use in poor working-class neighbourhoods when the use of illicit drugs was a more widespread social phenomenon was an issue which captured my sociological imagination and sent me on a journey from an initial series of confused and wide-ranging research questions to a more streamlined and coherent 'intellectual puzzle' which shaped this research investigation of class, community and drug use.

My enquiries began by interrogating the evidence for the uneven social and spatial location of problematic drug use - was this a 'real' or a socially constructed phenomenon relating to how drug use was defined in disadvantaged communities? And, if the former, would the concepts of social exclusion and risk environments help elucidate this phenomenon?

My initial reviews of poor neighbourhoods suggested that local social problems and structural deficiencies could facilitate the development of a risk environment that fostered the growth of neighbourhood drug scenes. However, the literature on drug use also indicated that social and interpersonal processes were key in the development of drug careers. As a result, it seemed that this investigation warranted an examination of the relationship between social exclusion and localised drug problems at both the micro and macro level i.e. the social and cultural processes as well as the structural forces that could facilitate local drug problems.

Research aims

After much reading and hypothesising, I decided the main aim of my thesis should be to explore the interplay between the lived experience of social exclusion and the development of drug careers. In so doing, I would use the concepts of social exclusion and risk environments as heuristic devices for understanding the processes which influence the disproportionate location of drug problems in marginalised areas.

More specifically, I set out to examine:

- i) how drug careers develop in risk environments;
- ii) whether structural problems (such as economic inequality, educational disadvantage, poor housing, high unemployment, the lack of meaningful roles for young people) play a role in the development of localised drug problems;
- iii) how issues relating to drug accessibility, treatment options, social and family networks impact on drug-using careers; and
- iv) what role the informal economy and the drugs market plays in the development of localised drug problems.

My sociological curiosity in these issues was interconnected with my methodological preference for seeking to understand social phenomena from the perspective of those involved, and for locating their meanings within the social, cultural and structural contexts of their environment. Both the research topic and this epistemological standpoint influenced the research methodology developed, resulting in a multi-method approach that would capture the varied elements of my investigation.

Overall, this study aimed to contribute to knowledge about the nature of localised drug problems and their relationship with social exclusion, thereby informing grounded policy interventions. At a theoretical level, I wished to examine macro- and micro-level social theories and their utility in assessing the complexities of the lived experience of spatially located social exclusion.

Locating the study

With both my key research questions and a broad methodological framework outlined, the final decision I had to make, at the initial stage, was where to conduct the fieldwork.

When I first began exploring the idea of conducting a PhD study on this issue, I lived and worked in London. However, my initial literature reviews indicated that the relationship between disadvantage and problem drug use seemed even clearer in my home country of Ireland than in the UK. In addition, Dublin's then racially homogenous population presented an opportunity to explore the issues of social exclusion and drug use in a 'race neutral site' and thus highlight the centrality of social class in my investigation of drug problems in marginalised neighbourhoods. In this respect, I applied for and received a research grant for two years from the Health Research Board in Dublin to conduct this study. I began the fieldwork in April 1996 and for the duration of the grant was able to work on it full-time. However, since mid 1998, the exigencies of full-time work and life's ups and downs have hindered its completion. Nonetheless, I continued to persevere, albeit slowly, in the hope that this work may add to our understanding of an issue which continues to frustrate even the best-intentioned policies and plans, and which for me is symbolic of the deep-rooted inequities in our world.

A note on terminology

Before commencing this work, I wish to note the disparate terminology used in the drugs field and the implications of this for drugs research. I also wish to clarify my intended meanings in relation to the terminology used in this study.

Problem drug use

In the drugs literature, the terms 'use', 'misuse', 'abuse' and 'addiction' are used to describe a multitude of drug-taking phenomena from cannabis smoking to intravenous heroin use. The choice of term used by authors appears to be influenced by factors such as professional bias (those in the field of psychiatry showing a preference for the term 'abuse' in contrast to sociologists' preference for the term

'use' and 'misuse'); geography and culture ('use' and 'misuse' being more favoured in Ireland and the UK while 'abuse' is more common in the United States); and/or the authors' ideological and moralistic standpoints (cf Hartnoll, 1995a; Butler, 1997). In the literature review of this study, I use the terminology used by the authors in their work. However, my own preference is for the terms 'drug use' and 'problem drug use' and I use these as appropriate.

Nonetheless, the focus of this study is on problem drug use, in this respect I have been guided by the EMCDDA definition viz: 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines'.² In this work I use the term 'heroin use' interchangeably with 'problem drug use' as, at the time of the study, localised drug problems were most commonly associated with the use of this drug. Some readers may find my designation of a person's drug use as 'problematic', as an implicit value judgement, this is not my intention. Indeed it is a moot point that problematic use from the perspective of a drug taker may vary from what is considered problematic by their family, community and/or the institutions of health and social control. However, in focusing on problematic drug use I wish to make a clear distinction from drug use which is occasional, recreational, controlled and in general non-problematic.

Deviancy and delinquency

The terms 'deviant' and 'delinquent' have moral connotations, similar to those invoked by the term drug abuse, in their implication that a behaviour is outside the norm of what is deemed culturally acceptable in its society. In this study, the terms are used to explore sociological and criminological theories which may be helpful in understanding and conceptualising localised drug problems. However, as noted by Matza (1964), the social construction and labelling of drug users as deviants is a process inextricably related to power relations and dominant ideologies in society. Thus the terms are used here with care, and often in single inverted commas, to alert the reader of its value-laden nature.

² This definition of problem drug use has been agreed by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) for the purposes of conducting comparable research among the EU members, see www.emcdda.eu.int.

Disadvantage and deprivation

Difficulties are also experienced in finding the appropriate terminology to describe the lived experience of socio-economic and cultural inequality. In this respect, the concept of class is now often regarded, although not by this author, as an outmoded concept which lacks clear sociological meaning. The terms disadvantage and marginalisation are useful, albeit general terms, and will be used in this work to describe people and places experiencing poverty and relative deprivation. In so doing, I am nonetheless aware that neither of these terms are likely to be used by those to whom they are applied.

Structure of the thesis

This thesis begins with a review of the English language literature on problem drug use covering a wide range of issues such as risk factors; the link between drug use and disadvantage; the spatial clustering of drug and social problems; the influence of local drug markets; the meaning of drug careers in disadvantaged communities; and, an exploration of the concepts of social exclusion and risk environments. This review is followed by an in-depth account of the methodology and methods framing this study.

The data chapters begin by an examination of comparable quantitative data for the five 'heroin' neighbourhoods examined for this study, this is followed by a ethnographic and qualitative description of the neighbourhoods and the local context in which drug problems develop. The following chapter profiles the heroin users who were interviewed for this study and provides an account of the development of their drug careers. Chapter Six examines the dynamics of local drug markets and the issue of illegitimate opportunity structures. In the three remaining data chapters, the focus of attention shifts somewhat to the options, opportunities and support that were available to the heroin users in their neighbourhood, here the issues of education and employment, family and relationships, and drug treatment options are explored. In the concluding chapter, the key themes identified in this study are drawn together with special reference to issues of spatially-situated social exclusion, risk environments, the meaning of drug use in excluded lives, and the implications for policy.

Chapter Two

Literature Review

Introduction

My doctoral thesis sets out to examine the dynamic interplay between the development of drug careers and the lived experience of socially excluded neighbourhoods. To provide a conceptual and theoretical framework for this investigation, my literature review examines the shape of the English language literature (mainly from the UK, Ireland and the United States) on drug and area based social problems in four sections:

First, the review considers the evidence in relation to the aetiology of drug use and the risk factors relating to peer, family and setting influences.

Secondly, the review looks at the evidence relating to the link between drug use and disadvantage, the clustering of drug problems in disadvantaged neighbourhoods, and the influence of local drugs markets and distribution networks.

Thirdly, the review examines evidence relating to the drug situation in Ireland.

Fourthly, theoretical explanations relating to social problems and the concepts of social disorganisation, social exclusion and risk environments are assessed.

Each substantive topic is assessed in turn indicating current thinking in the field with particular reference to the methodologies underpinning these works. To conclude, this chapter signals the gaps in our understanding of localised drug problems which this thesis seeks to bridge.

Although I began this review at the outset of my study, as time passed and the analysis of my fieldwork continued, the review has been amended and expanded to include work published during the later period of my work.

Section 1: *The aetiology of illicit drug use*

For many years a key feature of the literature on the aetiology of illicit drug use, and related risk behaviour, was its focus on individualistic explanations located in the fields of psychobiology and psychopathology. Such theories provided a broad range of explanations, such as genetic disposition; a constitutionally determined response to drug use; a personal disposition to take risks and pursue momentary pleasure; alienation from conventional norms of behaviour; and, exposure to cultural pressure (especially from other young people) to take drugs. However, since the 1980s there has been a growing tendency to acknowledge the environmental context of drug use and related risk behaviour (cf MacGregor, 1989; Dickerson and Stimson, 1995; ACMD, 1998).

In this respect, the ACMD (1998) report *Drug Misuse in the Environment* assessed the relevant evidence under the broad headings of micro- and macro-environmental influences. This helpful dichotomous approach placed the more immediate aspects of an individuals' interpersonal environment such as family, friendship networks, the school and workplace in the former category while social, economic and cultural factors were assigned to the latter. The approach marked an attempt to distinguish between, what I term, social processes and structural forces. However, while the distinction is useful, it is one that was found difficult to maintain. For, as noted by the ACMD (1998, p34), it is often difficult to extract micro environmental influences of family and peers from the wider environmental consequences of neighbourhood, poverty and social exclusion.

Risk factors

Many of the micro-environmental factors identified in the ACMD (1998) report had previously been examined in the drugs literature as risk factors. And significantly, over time, this literature has come to differentiate between risk (and protective) factors for problem drug use as opposed to those for drug use (Health Advisory

Service, 1996; Gilman, 1998). For, as noted by Glantz and Pickens (1992) risk for use does not predict the transition from use to abuse, and vulnerability to use seems to be largely distinct from vulnerability to abuse.

Risk literature on problematic drug use has identified a range of factors which may be broadly categorised under psycho, social, familial and peer issues. In addition, specific risk groups regarded as being particularly vulnerable to problematic drug use have been identified, such as those excluded from school; truants; children in care; young offenders; young homeless; children of drug misusing parents; and young people not in education, work or training (Health Advisory Service, 2001). However, while studies (such as Lloyd, 1998) may point to an overlap or interconnectedness between these risk factors and risk groups they rarely consider the influence of the physical/structural environment or question whether the incidence of these factors and/or groups is spatially concentrated.

Peer influences

Literature on risk factors for both drug and problem drug use covers a broad range of peer related issues such as the effect of peer rejection, peer pressure, peer selection and/or peer networks. However, these issues are complex and require, as suggested by Lloyd (1998, p223), an unravelling of the sequences and consequences of relationships and drug use.

In addition, the ACMD (1998) note that the emphasis on the term 'peer pressure', which implies that the individual is a passive and even unwilling victim, does not accurately describe the dynamics of consensual drugs markets and the notion of volition and or desire. Oetting and Beauvais' (1988) concept of 'peer clusters' - small, cohesive, and marked by shared attitudes and beliefs – appears to be a useful way of seeing how such consensual drugs markets might operate.

According to Pearson (1987b, p80), "friendship is the essential lubricant of drug exchanges" in that it is much more likely that a drug offer will be accepted from a friend than a stranger or a pusher. Pearson (1990) also notes that when drugs become available locally, the predominant means by which they circulate is through friendship networks. Consequently, he regards the myth of the 'pusher' as being

entirely unhelpful in understanding risk factors at the local level. These views are supported by the findings of earlier studies (Pearson, 1987; Pearson, Gilman and MacIver, 1987; Parker, Bakx and Newcombe, 1988), where friendship networks were invariably found to be the means by which people were introduced to, in the case of these studies, the use of opiates.

The importance of peer networks in the development of localised drug problems was also identified by De Alarcón (1969) who noted how the social links of common school and neighbourhood, or common haunts of amusements (pubs, dance halls, bowling alleys etc.) facilitated the spread of heroin use through the network.

Such drug-using networks have a further important role in terms of the interpretation and meaning of drug effects. In his account of marijuana users, Becker (1963) noted that drug effects are 'learned behaviour' through group processes, rather than an automatic outcome of taking the drug. In this sense, the peer network may also be viewed as being less about 'peer pressure' and more about providing a system of interpretation and meaning of drug effects (ACMD 1998, p30-31).

Family Influences

It is also worth noting, as Lloyd (1998) reminds us, that peers also include siblings and partners. A distinguishing factor of problem drug use in Dublin is the inter-familial and inter-generational aspect of this phenomenon in the clustering of drug problems within families and over a number of generations (cf McCarthy, and McCarthy 1997; MacCarthaigh, 2000). However, the research evidence is inconclusive as to whether inter-familial substance problems are genetically or environmentally determined (Pickens and Svikis, 1991; Cadoret, 1992). Evidence of sibling drug use (Merikangas, Rounsaville and Prusoff, 1992) points to the latter factor being key, particularly when peer and parental influences were controlled (Brook et al. 1998).

Kumpfer and Alvarado (1995) demonstrate that parental substance misuse is a high risk factor for problem drug use. The impact of such familial drug use was noted in McKeganey, McIntosh and McDonald (2003) to result in pre-teens being five times more likely than their peers to have initiated some form of drug use when someone

in their (extended) family was using illegal drugs. This was seen to be due to the increased likelihood of their developing a positive attitude towards illegal drugs and/or being able to access drugs or drug-using paraphernalia.

The ACMD (1998, p34-35) review notes the long tradition tracing delinquency (and by association drug use) to a broken home, and by implication lone-parent households. However, the meta-analysis conducted by Wells and Rankin (1991) on the impact of broken homes clearly identifies family process, rather than family structure, as the crucial variable.

Setting

The issue of peer networks was also explored by Zinberg (1984) as one aspect of the *setting* which differentiated controlled from compulsive drug use. The setting, which Zinberg defined as the physical and social setting in which drug use occurs, involved both social sanctions and social rituals, factors which have been seen to offer some explanation for the many Vietnam veterans who, after being exposed to a readily available supply of heroin, gave up their drug use when they returned to their civilian way of life (Robbins, Helzer and Goodwin, 1974).

Zinberg's study (1984) showed how compulsive users had a narrower range of friendship types and social connections than controlled users. For example, they tended to know more compulsive users and fewer controlled users or users of non-opiate drugs, and so they seemed to be cut off from the limiting influence of more moderate drug takers. In this sense, Zinberg maintains that the way a person uses heroin is a function of group membership - controlled use is supported by knowing controlled users and also by simultaneously belonging to groups where heroin is not used.

Grund's (1993) work provides a valuable extension to the more micro oriented aspects of the social setting considered by Zinberg. In addition to the rituals and rules which Zinberg had identified as the social setting, Grund (1993) added 'drug availability' and 'life structure' which were seen as interactive components, each mutually reinforcing the other and bolstered by external determinants. Citing Faupel (1987), Grund defined the stable life structure as the regular activities (both

conventional and drug-related) that structure daily patterns, such as relationships that are demanding and simultaneously valuable in social or economic ways; regular contacts with controlled and non-drug users; and participation in structures and activities not primarily driven by drug-related incentives.

Both Zinberg's (1984) and Grund's (1993) analysis of the factors which separated the addict from the controlled user indicate the importance of the user having other values, activities and personal relationships so that the drug does not dominate their lives, in short, what may be termed options and alternatives.

I shall return to the issue of opportunities and alternatives later in this chapter in the context of sociological theories. Before doing so, I will first examine the evidence relating to the relationship between drugs and deprivation.

Section 2: *The drugs-deprivation nexus*

Prevalence surveys of illicit drug use among populations have noted little evidence of a relationship between 'use' and either class or indicators of socio-economic disadvantage (for example Leitner, Shapland and Wiles, 1993; Parker, Measham and Aldridge, 1994). However, it is the far rarer phenomenon of problem drug use which appears to have a distinct social bias. Certainly since the outbreaks of epidemic heroin use in Ireland and the UK in the 1980s, a strong association with socio-economic disadvantage and heroin use has been noted (cf Pearson *et al.*, 1987; Parker *et al.*, 1988).

However, the association between problem drug use and socio-economic disadvantage can be seen to differ over time and space. For example, initial studies of heroin users in the UK showed no class or socio-economic relationship (for example Stimson, 1973; Auld, Dorn and South, 1984). Furthermore, while Hartnoll's (1995b) multi-city study found a strong association between addiction and relative social deprivation in cities such as Paris, Barcelona, Dublin, and Stockholm, this did not hold true for all cities. For example, heroin addiction was more widely spread across social groups in Geneva, and to some extent in London.

Inconsistencies such as these indicate the complexity of this issue rather than a straightforward unilinear and causal relationship between the two variables, as noted by the ACMD (1998). However, terminology, how socio-economic disadvantage/deprivation is defined, and the research methodologies employed in the relevant studies play a part in explaining these variations, as will be discussed below.

Unemployment and drug use

Unemployment has been one of the key indicators of socio-economic disadvantage used to ascertain whether problem drug use is related to disadvantage. For example, Peck and Plant (1986) revealed significant correlations between unemployment and the extent of known drug misuse. Likewise, the OPCS³ Psychiatric Morbidity Survey (Meltzer, Gill, Petticrew and Hinds, 1995) found the level of drug dependence six times higher amongst those who were unemployed than amongst those who were employed. However, such statistical correlations do not necessarily imply causality between the variables (Pearson, 1987b, p66). Unemployment may have preceded or followed the individual's development of a drug problem. (cf Zinberg, 1984). Or, the population sampled may have been attending drug treatment services and unable to work. Consequently, the sequence and meaning of unemployment in a drug career is important to record and understand.

It is also worth noting that how unemployment is defined in a research study will affect the analysis of its relationship with problem drug use. The use of socially constructed unemployment statistics, for example whether they include first time job seekers, those on training courses etc., influences the outcome of this type of research analysis. Unfortunately, not all studies examining the relationship between these two variables are explicit as to the definition of employment they have used in their research.

³ OPCS - Office of Population Census and Surveys.

The meaning of unemployment

The psychological impact of unemployment has been noted in a series of research studies (for example by Jahoda, Lazarsfield and Zeisel, 1972; Whelan, 1994b) and is seen to range from loss of status and identity; apathy and despair; loss of social interaction and social contacts; mental and physical ill health; and the destruction of temporal structures which order daily life.

Becker's (1963) notion of a 'drug career' has proved a useful tool in depicting how heroin use, in the absence of employment opportunities, can provide meaning and structure to life. For example, Pearson (1987b, p87) noted that "heroin use within the context of unemployment takes on a new significance, as an effective resolution of the problem of de-routinised time-structures". In this respect, dependence on heroin, quite literally, imposes its own rigid time-structure - the 'ripping and running' described by Agar (1996).

In contrast, the stabilising nature of employment on drug use was noted by Zinberg (1984) and Peele (1985), who suggested that it is the absence of valued life commitments, such as employment, which makes stable forms of recreational drug use less likely.

However, many of the studies examining the meaning of unemployment do so at an individual level. Later in this chapter, the work of Wilson (1993, 1997) dealing with the impact of 'joblessness' on communities and the implications of this for neighbourhood drug problems will be discussed.

The clustering of drug problems

The Chicago School studies of the spatial location of social problems (cf Dai, 1937; Faris and Dunham, 1939; and Shaw and McKay, 1942) found the highest concentrations of drug-related problems in the poorest urban neighbourhoods. Findings which were replicated by later ecological studies focusing on drug problems (cf Chein, Gerard, Lee and Rosenfield, 1964; Hughes 1977; Fagan and Chin, 1991). One of the earliest of these U.S. studies explored the relationship between aspects of social deprivation and the likelihood of an area being affected by epidemic heroin

misuse (Chein *et al.*, 1964). Their findings noted that the geographical distribution of heroin was strongly related to ecological measures of poverty, unemployment, overcrowding and family breakdown.

Similar ecological type studies conducted in the 1980s in England and Scotland highlighted how heroin epidemics had settled in economically depressed working-class communities. These studies used a range of deprivation indicators, such as poor housing; low income; a high density of single-parent families; council tenancies; and unskilled employment to measure against area drug problems (see for example by Haw, 1985; Peck and Plant, 1986; Burr, 1987; Pearson *et al.*, 1987; Parker *et al.*, 1988; Giggs, Bean, Whynes and Wilkinson, 1989; Mirza, Pearson and Philips, 1990).

However, the terms 'deprivation' and even 'relative deprivation' are contested issues in terms of their conceptualisation. As a result, the variables used to define these terms will depend on factors such as the availability of appropriate data and the ideological standpoint of the researcher (whose choice of variables may not necessarily be those which the people experiencing the deprivation would choose). Accordingly, the manner in which deprivation is defined will both influence the outcome of such studies and the capacity for valid comparisons between them. Furthermore, some studies have prioritised indicators of material deprivation to the detriment of cultural deprivation. For example, Parker *et al.* (1988) used the variable 'use of a car' as an indicator of material deprivation while indicators of cultural deprivation, such as the level of educational disadvantage in the area, were not included.

Deviant cases

It is a moot point to note that while drug problems are seen to cluster in areas of disadvantage, this is neither a rigid or an exclusive rule i.e. not all disadvantaged areas are hosts to drug problems and drug problems exist in other areas also. For example, in the North-East of England, Pearson *et al.* (1987) showed that heroin misuse was most densely concentrated in neighbourhoods that were experiencing exceptionally high levels of unemployment. However, they also noted areas with very high unemployment rates which seemed largely untouched by the heroin epidemic. Later, Pearson (1990) was to account for these discrepancies by suggesting that

drug distribution networks and availability of the drug were necessary for drug problems to develop in a neighbourhood.

The Wirral study by Parker *et al.* (1988) also found that the correlation between heroin misuse and deprivation did not hold for all areas. However, the study noted, that the relatively prosperous areas with high levels of heroin misuse were in close proximity to townships with high levels of both heroin misuse and unemployment. As a result, the authors suggest that geographical proximity had assisted the effective working of local drug distribution networks in these areas, whereas the areas with high levels of deprivation and low levels of drug misuse were geographically remote.

I will return to the issues of availability and distribution networks later in this review. Meanwhile, the inconsistencies indicated by the deviant cases above are helpful in demonstrating that relationships between individual variables are not always straightforward and that the issue of neighbourhood dynamics is multidimensional and complex.

Urbanism and housing policies

The Chicago school ecologists held that the spatial development of cities was due to factors such as natural processes of settlement and/or competition for space etc. However, it is important to note, as does Harvey (1985), that urbanism is not an autonomous process and needs to be analysed in the context of political and economic change. In this sense, the urban environment reflects social and economic systems of power (see also Sibley, 1995).

The relationship between power and space is most evident in housing policies which cluster individuals and families experiencing multiple disadvantage within confined areas. Structural analyses of such policies provide an additional perspective to understanding the process of 'drift' and the view of drug addicts drifting, as if by chance, to neighbourhoods where their needs and values are shared. For example, in the UK, local authority housing allocation practices were seen to give rise to 'sink estates' as a result of the 'dumping' of problem families in less desirable areas (Morris, 1957; Gill 1977). This policy had the knock-on effect of creating 'hard to let' estates as more stable tenants turned down housing offers in these estates because

of their poor reputation (Wilson, 1963; Baldwin and Bottoms, 1976). This, in turn, led to a concentration of residents with most urgent housing needs forming “huddles of poverty” which, Pearson (1987b, p73) maintained, facilitated heroin misuse and dealing networks through *inter alia* the increased likelihood of squatting and boarded up properties. In addition, housing policies which lead to a high population turnover have been seen to prevent the formation of a stable community and contribute to social disorganisation (Shaw and MacKay, 1942).

In Ireland, the impact of similar housing policies was exacerbated by the introduction in the late 1980s of a ‘surrender grant’ payable to local authority tenants willing to give up their tenancies and purchase a private dwelling. This policy was intended to free up public housing and stimulate the construction industry (Threshold, 1987). However, as Fahey (1999, p39-40) note, this was widely regarded as a disastrous episode in Irish housing policy as it led to a sudden exodus of the better-off tenants from the more deprived estates and their replacement by mainly welfare dependent households. The outcome, as Fahey notes, was “a brief but intensive push to the process of residualisation in those estates” (*ibid*, p40). Many of these estates were the same areas where drug problems became endemic a few years later.

Neighbourhood tolerance

However, it is not just the built environment which may be influential in the development of local drug problems. As noted by the ACMD (1998, p67) “the environment is as much about the surround of ideas as about physical structures.” In this sense, the ACMD note an environment of awareness and beliefs operating at several overlapping levels. These range from the larger society, to the neighbourhood, the family, and to the individuals themselves and the immediate world they move in outside the home. For example, the ACMD (1998, p30) notes the influence of youth cultures and subcultures e.g. music and popular culture on drug taking, and suggest that access to drugs involves not just material access but also ‘being accessible’ to a cultural and symbolic realm i.e. to the promise or intended meanings of drugs. In this sense, Parker, Aldridge and Measham’s (1998) normalisation thesis demonstrates how the use of drugs, such as cannabis (as distinct from problem use), are an accepted part of youth lifestyle.

At a neighbourhood level, attitudes such as these may also be influential, for as noted by Brook and Brook (1990), one of the main environmental variables associated with substance abuse is that of an atmosphere of tolerance of drug use and the perception of drug use as relatively safe. These issues tie in with Zinberg's (1984) concept of 'setting', discussed earlier, and also provide further understanding of opiate use by US soldiers in Vietnam in that, according to Gossop (1996), being in an environment devoid of many social and moral restraints increased the likelihood of drug taking.

Access and availability: local drugs markets and distribution networks

The issue of availability through local markets and distribution networks have been identified as key to neighbourhood drug problems (see for example Pearson *et al.*, 1987; Parker *et al.*, 1988).

Pearson (1987b, p75) noted a type of 'catch 22' scenario occurring in neighbourhoods whereby the presence of problem drug users increases the local availability of drugs. In this respect, 'user-dealers' who deal in order to support their habit circulate drugs, especially among friendship networks, and the roles of 'buyer' and 'supplier' are frequently interchanged. As a result, the presence of drug users in a locality makes it highly likely that low-level dealing networks will develop within the area.

However, as Moore (1977) noted, the drug must be available at an 'effective price' in terms of monetary price, search time etc. since a novice user is less likely to be prepared to endure too many inconveniences in pursuit of a drug compared to habitual users. Nevertheless, Pearson (1987b) noted that while availability is crucial to the dissemination pattern of drug use, availability itself cannot explain why people choose drugs; employment, he suggests, may be an influential factor.

A number of research studies have established that people already involved in 'delinquent subcultures' in poor neighbourhoods will be more likely to become involved with drugs, either as small level dealers or users (Auld, Dorn and South, 1986; McGahey 1986; Burr 1987). It is a moot point whether deviant behaviour precedes or follows problem drug use, either by involvement in acquisitive crime or

drug dealing to finance drug use. However, as will be discussed later, deviant behaviour too has a context in that, as Bagley (1965) and Downes (1966) noted, it can provide alternative entertainment where few opportunities for legitimate entertainment exist.

It is also useful to note, as have Johnson *et al.* (1985), that from an economic standpoint, drugs markets may make some positive contributions to an area, such as the sale of stolen goods below their normal price which enlarges the purchasing power of poor families. In this respect, Auld *et al.* (1984) argue that at a local level the consumption and supply of heroin is part of a broader response to the problems and opportunities of recession.

Many of the themes identified in this section will be explored further in the theoretical section which concludes this review. First, though, I will review the drug situation in Ireland in order to outline the cultural and local specificities of the situation and to provide a framework for the final part of this chapter.

Section 3: *The drug situation in Ireland*⁴

Historically, drug use in Irish culture has been linked to alcohol use, primarily to the illicitly brewed spirit *poitín*, as well as whiskey and Guinness. Although no studies have unearthed evidence of opium use among peasant workers or indeed the Romantic poets as was the case in England (cf Berridge and Edwards, 1981), the preponderance of mythical creatures such as fairies and leprechauns in Irish folklore may not be unrelated to plentiful supplies of 'magic mushrooms' (psilocybin) among the native flora.

In Dublin, illicit drug use first came to public attention in the late 1960s, at which time LSD and cannabis were found to be the most commonly used drugs (Masterson, 1970). In the 1970s, trends such as glue sniffing among school children, and tranquilliser and barbiturate misuse among adults were noted (Flynn and Yeates, 1985). However, towards the end of the 1970s, health and welfare workers identified a new phenomenon of opiate use which was concentrated in small pockets of

⁴ This section is based on material which first appeared in O'Gorman (1998).

Dublin's inner city with a history of poverty and disadvantage – high levels of unemployment, low levels of education, poor housing (mostly in local authority flat complexes) and a lack of facilities for young people (O’Gorman 1998).

Several small-scale community studies carried out in those areas give an indication of the situation at the time. A report on a north inner-city area found 10% of the 15-24 year age group using heroin (Bradshaw, 1985), while a similar study in a south inner-city ward found a rate of 9% in the same age group, and a rate of 14% among young men (O’Kelly, Bury, Cullen and Dean, 1988). These young opiate users belonged to a predominantly injecting drug culture, a phenomenon that was to have serious repercussions later in terms of HIV transmission.

Since 1990, The National Drug Treatment Reporting System (NDTRS) has been the main systematic source of information on illicit drug use (for example, O’Hare and O’Brien, 1992; O’Higgins, 1996). The findings of these reports have made a substantial contribution to Irish drug policy debates in that they have consistently reported two interesting sociological phenomena. First, that the profile of the typical drug user in treatment is male, single, from a disadvantaged socio-economic background with a low educational achievement and a poor employment record. And secondly, that when the data on the area of residence of those attending treatment is viewed spatially, the clustering of drug users in treatment matches areas of identified disadvantage in Dublin’s inner-city and outer estates. However, the NDTRS data only reflect those drug users receiving treatment and a number of caveats regarding the validity of the data should be applied.⁵

On their own, the representativeness of the NDTRS data may be queried. However, as they match other data such as anecdotal evidence from residents and workers in these communities, media reports, and official police data⁶ the link between problem drug use and spatially concentrated socio-economic disadvantage in Dublin is

⁵ For example, at the time of this study, not all treatment agencies or GPs submitted data to the database, so the figures underestimate the numbers in treatment. The treatment of all illicit drugs, from cannabis to heroin, is included in the figures. And, as not all drug users attend treatment, the figures underestimate the total prevalence of drug use. As a result, it is not known how representative the data are of the drug-using population as a whole.

⁶ Although whether police arrest and seizure data reflect trends in drug use or the level and focus of Garda activity is a debatable point.

indisputable. Indeed, in 1996, the Government launched a new policy initiative establishing 'local drug task forces' in a number of disadvantaged areas on the basis that:

"There is a high correlation between the areas where the [drug] problem is most acute and the areas which have been designated on the basis of objective criteria, as economically and socially disadvantaged" (DoAT, 1996, p27).

The link between heroin use and deprivation in Ireland was given further credence with the publication of a capture-recapture prevalence estimation study (Comiskey, 1998), which firmly located the opiate using population in disadvantaged areas of Dublin city. However, at the time of this study, no substantial level of problem drug use had been identified outside the Dublin area even though pockets of deprivation exist in other cities. This could perhaps indicate that distribution networks and drugs markets had not yet been established outside of Dublin.

Additional data from the NDTRS and other studies provide further information on problem drug users in Dublin. For example, correlations with unemployment (O'Kelly *et al.*, 1988; Hutchinson, Keenan, Cheasty, O'Connor, and McCarthy, 1995; Keogh, 1997); early school leaving (for example Dean, Lavelle, Butler and Bradshaw, 1984; McCarthy and McCarthy, 1997; Comiskey, 2003); and early age of first use (Dean *et al.*, 1984; Lavelle, 1986; McCarthy and McCarthy, 1997) have been established; as have the inter-familial and inter-generational aspect of this phenomenon, as noted earlier in this review. On a related topic, the NDTRS data (for 1997 and 1998) also noted that two-thirds (66%) of drug misusers in treatment were living in their parental home (O'Brien, Moran, Kelleher and Cahill, 2000).

Illicit drug use in the 1990s

In the early 1990s an ecstasy/rave culture developed in the Dublin youth scene. Initially this fashion was centred around a few large dance venues in the city centre, but the trend has since spread to other urban areas. Evidence indicates that the use of ecstasy and cannabis has become increasingly normalized among young people, transcending class and urban/rural divides.

In the mid-1990s, a second opiate epidemic was seen to have developed in Dublin

among a new generation of young heroin users. Initial analysis of this situation focused on the connection between ecstasy use and opiate use following a number of young opiate users coming into treatment having first smoked heroin to 'come down' from ecstasy (see Smyth, O'Brien and Barry, 2000). However, it has since emerged that those ecstasy users who moved on to opiate use were, in the main, young adults from the marginalized inner-city and suburban public housing estates where heroin was readily available and at an all time low price (O'Gorman, 1998).

To summarise the drug situation in Ireland at the onset of this study, evidence consistently indicates the spatial overlap between concentrations of problematic drug users and concentrations of people experiencing multiple disadvantage in Dublin's inner-city and outer estates.

Having presented the evidence on the clustering of drug problems in the international and Irish literature, I now turn in the concluding part of this review to examine the theoretical explanations for neighbourhood drug problems.

Section 4: Theorising neighbourhood drug problems

The Structuralist view that deviant behaviour, such as crime and drug use, results from unequal access to opportunity because of an individual's position in the class structure (i.e. that there is greater pressure on the working class to deviate because they have less opportunity to succeed by socially ascribed legitimate means), offers a useful starting point to investigate theoretical explanations for drug problems in disadvantaged areas.

Retreatism

Merton's (1957) analysis of the impact of restricted opportunities and, in particular, individual's responses to the mismatch between their aspirations and their opportunities, is helpful in constructing the theoretical framework for this thesis. Two of the responses identified by Merton have particular relevance to this discussion. First, that of the 'innovators', who embrace the socially endorsed value of success but have little access to achieving this through conventional and legitimate means. This group, according to Merton, reject normative means in favour of deviant means

and achieve success through, for example, the informal economy and the drugs market. The second response of relevance is that of the 'retreatists' such as drug addicts. This group was seen to have internalised both the cultural goals and institutionalised means of achieving success, but unable to attain the latter, resolve the conflict of their situation by abandoning both the goals and the means of reaching them. Unable to cope they drop out of society, defeated and resigned to their failure.

Cloward and Ohlin (1960) added an additional perspective to Merton's analysis by proposing that retreatist subcultures were developed by lower class youth, mainly around illegal drug use, because they failed to succeed through either legitimate or illegitimate opportunity structures.

Merton (1957) and Cloward and Ohlin's (1960) view of drug addiction as an escapist or retreatist response from anomic situations of hopelessness and squalor was taken up by Chein *et al.* (1964) who noted that the pleasure-pull of opiate use had much to do with the relative destitution of the life of the addict regarding pleasure. In this respect, they speculated as to whether the sense of futility and hopelessness in slum districts increased the likelihood that young people would experiment with narcotics. A view later explored by Peele (1985) who noted the desire to continue returning to a state of bliss must be seen in the context of individual's values and their perceived alternatives.

Activism

The view of the passive escapist heroin user, however, has been increasingly challenged by research which has identified a more active aspect to the heroin user's lifestyle. For example, the work by Preeble and Casey (1969, p3) found that "the quest for heroin is the quest for a meaningful life, not an escape from life". Their seminal study of the street life of heroin addicts in New York identified the addict as a resourceful entrepreneur and that the constant routines and hustles of 'taking care of business' offered a "meaning [which] does not lie, primarily, in the effects of the drug on their minds and their bodies; it lies in the gratification of accomplishing a series of challenging, exciting tasks, every day of the week". (*ibid.*, p. 3)

Similar portrayals of active addict lifestyles can be found in the accounts of Feldman's (1968) 'stand up cat' and Sutter's (1966) 'righteous dope fiend' - the successful addict rarely seen in hospitals or clinics and who was often a local hero. Such active lifestyles were partly explained by the excitement attached to this way of life (the 'ripping and running' noted earlier) and the attraction of routine and structures in the context of unemployment. However, the appeal was also seen to be related to the status and identity that could accrue from a person's involvement in the drugs scene.

Status and identity

Cohen's (1955) work, contrasting somewhat with Merton (1957) and Cloward and Ohlin (1960), maintains that although lower working-class boys hold the success goals of the mainstream culture, due to educational failure and dead end jobs they have little opportunity to attain them. Instead, frustrated by their low status and restricted opportunities, they respond, not by turning to criminal paths to success as in the case of Merton's 'innovators', but by rejecting the success goals of the mainstream culture and replacing them with an alternative set of norms and values 'a delinquent subculture' through which they could achieve success and gain prestige. For, as shall be discussed later, in an environment where there is little opportunity to acquire 'legitimate' status, this identity is one of the few available.

The ACMD (1998, p40) note that in poor neighbourhoods, where young people experience exclusion from formal education and employment opportunities, drugs and crime can offer alternative means by which to demonstrate status and achievement (cf Feldman, 1968; Ricardo, 1994). In addition, low-level dealing can involve significant monetary gains (Johnson *et al.*, 1985; Reuter, MacCoun and Murphy, 1990) and offers tangible rewards for those prepared to take risks and able to exercise sufficient entrepreneurial skills (Williams 1989). Success within such local networks provides a means by which to claim status, respect, and sustain a meaningful lifestyle and identity, as demonstrated in the ethnographic descriptions of the everyday lives of addicts (see for example, Preeble and Casey, 1969; Johnson *et al.*, 1985; Burr, 1987; Williams, 1989; Gilman and Pearson, 1991). However, as noted by the ACMD (1998), studies of the street life of drug users, such as these, have invariably centred on male users and may offer little in terms of understanding female drug use.

The influence of heroin networks on local status systems were observed by Auld *et al.* (1984 and 1986) and Johnson *et al.* (1985). On the same issue, Hughes (1977), Hughes, Crawford, Barker, Schuman and Jaffe (1971), and Hughes, Barker, Crawford and Jaffe (1972) noted the likelihood that local opinion leaders would be the first to experiment with heroin and so the aspiration for status acted as a powerful motor in the local dissemination of heroin habits as others sought to be like them.

The dichotomy of the retreatist *v.* activist explanations for drug careers noted above implies contradictory positions, however, Hough (1996, p12) views these models as being "neither mutually exclusive nor incompatible with others: different sorts of explanation may be more appropriate at different stages of an individual's drug-using career. For many, drug use can become an important palliative to the problems that it has created or amplified, even if the initial stimulus was the search for status or structure."

Restricted opportunity v. cultural values

The notion of values, which is implicit in opportunity theories, marks a point of divergence for theorists seeking to explain the experiences of different social groups. Those influenced by Merton, such as Wilson (1997), focus on the structural underpinnings of opportunity and values in the context of poverty and welfare. In contrast, underclass theorists focus on the values of individuals and view the disadvantaged working class as having an intrinsic set of sub-cultural values different to mainstream society.

'Underclass' theorists can be seen to have been heavily influenced by Lewis' (1968) 'culture of poverty' thesis which proposed that it was not restricted opportunities *per se* that was the key issue but the transmission of values and attitudes from one generation to the next so that people are not geared to take advantage of increased opportunities. Developing this line of thinking further, Murray (1990) stressed the importance of cultural values and attitudes in creating a subculture where welfare dependency, lone parents, crime and drugs are the norm and lead to the isolation of the neighbourhood from mainstream society.

Social disorganisation

The debate as to whether people are constrained by restricted opportunities and/or pathological cultural values is carried through into the concept of social disorganisation which brings an additional perspective to explaining the concentrations of social problems in disadvantaged neighbourhoods. This approach draws from the ecological research studies of the Chicago School (such as Dai, 1937; Faris and Dunham, 1939; Shaw and McKay, 1942) which found social problems such as crime, deviancy, mental health and drug misuse spatially clustered in disadvantaged neighbourhoods. Social disorganisation is thus seen as a process whereby social problems mutually reinforce each other in neighbourhoods which bear the brunt of structural dysfunctions and adverse policies. For example, localised drug problems are seen to both stem from and contribute to community disintegration and the problems of marginal communities are exacerbated and reinforced by the impact of drugs on the whole community (see Dunlap and Johnson, 1992; Currie, 1993; Wilson, 1997).

Allied to the notion of the mutual reinforcement of social problems is an understanding of, what Wilson (1993, p21) terms 'concentration effects' i.e. the effects of living in an overwhelmingly impoverished environment. In this respect, Fischer's (1980) concept of 'critical mass' aptly illustrates how the level of disadvantage experienced by a critical mass in a given neighbourhood produces a synergy resulting in an overall level of disadvantage which is greater than the sum of its parts.

Although, Wilson (1987, 1997) too uses the term 'underclass' to describe the residents of urban ghettos and questions their value systems, in doing so he locates the explanation of their extreme economic marginality in the uneven impact of changes in post-industrial society rather than as a result of intrinsic sub-cultural values. In particular, Wilson cites joblessness and the out-migration of the non-poor as significant in the growth of concentrated poverty and as the catalyst for social disorganisation. In Wilson's view, the impact of accumulated poverty and disadvantage; the erosion of neighbourhood resources; the scarcity of appropriate role models; isolation from mainstream networks and detachment from dominant societal values provides the context for social disorganisation in a neighbourhood.

In contrast, Hannerz (1969) tackles the issues of cultural values head-on, adopting a more critically realist position by viewing culture as providing models of behaviour which are 'situationally adaptive', for example, single mothers make a rational choice of applying for welfare rather than taking up low-paid work. Hannerz argues (cited in Wilson 1993, p4) that Lewis's work on cultural transmission failed to draw a clear distinction between objective poverty created by cultural constraints and what counts as culture as people learn to cope with objective poverty. Hannerz, (1969, p179-180) notes that it is possible to recognise the importance of macro structural constraints and still see "the merits of a more subtle kind of cultural analysis of life in poverty".

Social exclusion

In Western Europe, the concept of social exclusion, rather than social disorganisation, became popular in European social policy discourses in the 1990s, to describe 'new' social problems which were seen to be related to, but more than, experiences of poverty, material deprivation and disadvantage (O'Gorman, 2000). Despite justifiable criticism of the concept for its vagueness and its appropriation as a politically expedient catch-all phrase, the concept offers potential for analysing the experience of those who are economically, socially and spatially excluded from mainstream society – for as Donnison (1998, p5) notes, it is an idea which poses the right kind of questions. In this respect, MacGregor's (2000, p119) suggestion that the explanation for social exclusion lies in a concentration of risks in individuals, groups and communities provides a useful framework for examining this issue, risks which, according to Ryan (1998), would include the breakdown of such socially integrative mechanisms as the Labour Market (jobs and income); the State System (access to education, health, housing and social services); and the Family and Community System (social networks).

In addition to stressing the dynamic, multi-dimensional and processual nature of disadvantage, the focus of much social exclusion literature on the institutional mechanisms expelling individuals, households and communities from society provides an added insight into the contested discourse on the significance of structural versus cultural influences. In this sense a lineage may be traced from strands of much contemporary writing on exclusion and alienation in society (for example Young, 1999) back to Merton's (1957) conceptualisation of anomie and the root of cultural

values in marginalised communities which precipitate crime and deviancy, and, by extension, drug use.

For Merton (1938, p677), "poverty, limited opportunity and a commonly shared system of success symbols" explained the high association of crime with poverty. In contrast, contemporary theories of deviancy focus on relative rather than absolute deprivation and meritocracy has been displaced by market values as the shared system of belief. For example, Young (1999, p26) describes the era of the late twentieth century, what he terms 'late modernity', as a dystopian society in which "the fundamental dynamic of exclusion is a result of market forces which exclude vast sections of the population from the primary labour market and of market values which help generate a climate of individualism", it is this "lethal combination of relative deprivation and individualism" (*ibid*, p48) which he sees as providing the explanatory context for crime and deviance.

Young's (1999) view of contemporary society as bulimic - assimilating while contemporaneously excluding a significant 'outgroup' – is echoed in the ethnographic studies of American inner-city neighbourhoods conducted by Nightingale (1993) and Bourgois (1995). For example, Nightingale argues that the combination of economic and social exclusion and cultural inclusion leads young people to compensate for their exclusion by (over)identifying with the trappings of mainstream culture such as the right clothes labels etc. and that the "culture of consumption has given them a seductive means to compensate for their feelings of failure" (*ibid*, p135). Rather than an absence of cultural values, the crucial issue here is that the excluded have, as Young (1999, p86) notes, "a *surfeit* of American values". In a similar vein of thought, Bourgois (1995, p326-7) notes the ambitious pursuit of the American dream through careers in the drugs economy by those relegated outside of mainstream society. However, as these careers often ended in failure Bourgois suggests that, because of their internalisation of success values, they resort to self-blame and the internalisation of their rage and despair and so direct their brutality against themselves and their community rather than against their structural oppressors.

Spatial exclusion and the 'risk environment'

While Young focuses on market values as a key feature of social exclusion, Byrne

(1999p, 128) goes further by locating social exclusion “as a necessary and inherent characteristic of an unequal post-industrial capitalism”. While viewing social exclusion as neither the property of individuals or social spaces, Byrne (1999), as does Sibley (1995), adds the perspective of urban geography to the discussion on social exclusion by focusing on socio-spatial relations and the spatial segregation of the excluded, noting how social experience is predicated by area of residence. For example, Byrne (1999, p110) notes that spatial location determines access to crucial social goods such as education and employment opportunities which have enormous significance for individual’s future life trajectory, as he observes, people “are badged by the space they occupy” (*ibid.* p.121). In turn, the ongoing labelling and stigmatising of the excluded and the tendency to focus on their personal deficits (Young, 1999; MacGregor, 2003) is facilitated by their spatial exclusion.

Recent research in the UK illustrates how illicit drug use is a central motif of socially excluded places impacting on the life trajectories of their inhabitants (Social Exclusion Unit, 1998; Foster, 2000; MacDonald and March, 2002). However, the evidence considered in this review leads me to consider that localised drug problems are not just a motif but an outcome of spatially situated social exclusion in that these ‘spaces’ provide a risk environment for the development of problematic drug careers.

While Rhodes (2002) definition of the risk environment as “the space – whether social or physical – in which a variety of factors interact to increase the chances of drug-related harm” (2002, p91) was developed in relation to HIV risk behaviour, the concept of a risk environment seems to offer scope in teasing out the interplay between the individual drug user and the structural environment they inhabit. Existing ethnographic work (such as Koester, 1994; Bourgois, 1995) which has examined drug use in the context of neighbourhood dynamics, provides useful examples of how doing so helps shift the focus of explanation from individuals to the social situations and structures in which individuals find themselves.

Policy implications

To conclude it is worth noting the policy implications of focusing on the social and structural context of neighbourhood drug problems.

Byrne (1999), Young (1999), and MacGregor (2003) all highlight how the dominant media and policy discourses portray the socially and spatially excluded *other* as if they were the masters of their own destiny (neatly avoiding any connection with the fallout from socio-economic systems and policies). And, as MacGregor (2003) also notes, even when social and drug policies adopt the rhetoric of social exclusion, they are often contradictory in their approach - on the one hand caring for, and on the other penalising, the drug user. The root of this contradiction, MacGregor (2003) suggests, is that social exclusion policies tend to focus on the reforming the individual rather than tackling structural inequalities.

Despite the duplicity demonstrated by this gap between rhetoric and practice, I believe it is important to hold on to, and re-appropriate, the term social exclusion so that drug problems are firmly placed and understood in this context. Otherwise, as cautioned by Stimson (1995 ,p18), while drug policies might try to minimise harm, the contexts of drug use in urban settings may contribute toward maximising harm for individual drug users and the community. In this respect, Currie (1998) notes that the failure to take the broader social, cultural and politico-economic context into account in explaining why low-income people living in economically and socially marginalized neighbourhoods 'abuse' drugs means that drug policies are continually compromised. For example, Currie (1998) notes how treatment programmes tend to over-medicalise drug problems and treat them allopathically i.e. each individual in isolation from the social context. He emphasizes that treatment programmes must include additional services that give problem drug users the opportunity to live a productive life as an educated, skilled, wage-earning member of society and cautions that even this will not be enough if programmes are not tied to broader efforts to revitalise poor communities socially and economically.

Conclusion

In seeking to understand the spatial clustering of drug problems in marginalised neighbourhoods, this literature review has covered a broad range of issues from a variety of academic disciplines. While correlations have been established between problematic drug use and indicators of social exclusion such as employment, early school leaving etc. there are many unanswered questions as to the process whereby drug careers develop problematically in excluded neighbourhoods. There is still a

need to capture, what Agar (1996, p57) terms as "the difference between aggregate statistical data and what going on in the world". As a result, this thesis sets out to capture the experience of multiple interconnected risks and constraints, and bring a dynamic perspective which "blends insights from the social sciences, merges quantitative with qualitative methodologies, [and] combines micro and macro views of society" (Leisering and Walker, 1998, pxiv) to tease out the complexity of the lived experience of risk environments.

Chapter Three

Methodology

Introduction

Following on from the literature review, this chapter outlines the methodological approach adopted to operationalise my research topic and the key research questions I had identified. Drawing on existing literature on methodology and methods in the field of sociology and drugs research, this chapter identifies the pragmatic and philosophical influences which guided my research study through the stages of design, fieldwork, data collection and data analysis.

The methodological approach

This study set out to explore the relationship between heroin use and spatially situated social exclusion. In this regard, the study seeks to locate the perspective and experience of the heroin users within the context of the social and economic structures in which they live and operate and focuses on the dynamic interaction of social processes and structural forces in marginalised neighbourhoods.

The methodological approach adopted for this study was influenced by a wide ranging body of research work from that of interactionists, such as Becker (1963) on the social processes of drug use; to sociologists from the 'Chicago school' (for example Shaw and MacKay, 1942) who had explored the spatial distribution of social problems by combining area-based statistical analyses with ethnographic studies; to the multi-method community studies of Pearson *et al.* (1987) and Parker *et al.* (1988); and to the work of critical ethnographers, such as Willis (1977) and Bourgois (1995), who had located qualitative evidence within a critical framework.

The aim of this research was to reach an understanding of how drug careers develop within the social and structural contexts of a risk environment. In this way, the main issues identified for investigation, were:

- a) the lived experience of heroin users;
- b) the social interaction between heroin users and their social and kin networks in the context of their neighbourhood; and

- c) the contextualising role of structural forces (i.e. demographics, unemployment, income, housing tenure and density, education etc.).

While critical theory provides the ontological basis for this study in terms of its perspective of 'reality' shaped by social, political, economic and cultural forces, overall, however, the methodological approach is probably best described as structural-interpretivism.

Assessing the dynamics between 'structure' and 'agency' in the development of localised drug problems, required a research design which would tease out the multiple interconnecting factors at play and elicit an understanding of individual experiences and meanings at the micro level, as well as the impact of macro level social structures. To capture the complexity of these dynamics a multi-method approach was adopted as the most appropriate. Consequently, the research design developed along the lines of a "field strategy that simultaneously combines document analysis, respondent and informant interviewing, direct participation and observation and introspection" (Denzin, 1970, p186).

The strategy selected entailed a three-pronged approach consisting of a quantitative analysis of the structural and macro-environmental influences which shape the contexts of marginalized areas; an ethnographic study to observe excluded neighbourhoods and to some extent participate in their world (following the Weberian tradition of *verstehen*); and qualitative in-depth interviews to capture the social processes and structural forces influencing the development of problematic drug-using careers in these excluded areas.

Research method

Knowing what you want to find out leads inexorably to the question of how you will get that information. (Miles and Huberman, 1984, p42)

Having decided upon a research strategy - although the fine-tuning of what it was that I wanted to know was an ongoing process during the fieldwork - I set out to operationalise this strategy by collecting:

- i) informative background data from statutory and voluntary workers in the drugs and related fields in the Dublin area;
- ii) primary ethnographic and interview data from heroin users, residents and relevant service providers in neighbourhoods with visible drug scenes; and
- iii) secondary data on structural factors impacting on these areas and on indicators of disadvantage and social exclusions.

Starting out

The first phase of my research study focussed on establishing contact with key informants in the field, developing an interview schedule, and analysing existing data on the spatial distribution of problematic drug use and on indicators of disadvantage and social exclusion.

My decision to conduct this doctoral study in Dublin entailed returning to live in Ireland after ten years living, studying and working in London. Although, I had kept up to date with developments in the drugs field in Ireland through contacts, media and research reports, I was conscious that I may have been missing out on some of the nuances of recent developments. Consequently, I spent the first four months of the research study establishing contact with a range of individuals and organisations who were either involved in service delivery for drug users or in drug-related work in excluded neighbourhoods. Contact was made with three key purposes in mind. First, to gather information on general views of the drug situation. Secondly, to identify the neighbourhoods in which to locate the study. Thirdly, to use their contacts to access the research population of heroin users.

At this time I also began collecting contextual data on the spatial distribution of problematic drug use, as well as neighbourhood data on indicators of disadvantage and social exclusion. Data on 'Treated Drug Misuse' from the National Drug Treatment Reporting System (O'Higgins, 1996; O'Higgins and Duff, 1997) provided the main source of information on the areas where drug misuse was concentrated, albeit, as noted earlier, these data related to individuals *reported* as being in treatment rather than all problem drug users. Nonetheless, the data pointed to a number of possible areas where the research might be located. This information was then compared with demographic and socio-economic data from the Population

Census for the smallest geographic units (publicly) available - District Electoral Divisions (DEDs). The areas with significant numbers of drug users in treatment were seen to corresponded to those areas with the highest levels of deprivation (see also O'Higgins, 1996) and those neighbourhoods were noted as possible locations for the study.

Developing the interview schedule

While my epistemological preference is for naturally occurring data, the research questions I had developed required that the bulk of the primary data be collected through in-depth interviews which would capture the life history of the heroin users regarding the development of their drug-using career and how their experience of social exclusion may have impacted on this: ethnography and observation alone could not inform on social and economic structures. I took some consolation from Schwartz and Jacobs' (1979) view that the researcher can gain information about 'ethnographic context' through flexible interviews. Therefore, I sought to keep the format for the in-depth interviews as flexible and loosely structured as possible while retaining sufficient structure so that the key data I needed to answer my research questions would be collected from each respondent. In this respect, my aim was "to generate data which give an authentic insight into people's experiences" (Silverman 1993, pix). As a result, based on the empirical and theoretical works I had read on drug use and social exclusion, I drew up an *aide memoire*, or interview schedule, of the topics that seemed most relevant to my investigation.⁷

The interview schedule (see Appendix 2) contained a list of topic headings on personal data, neighbourhood, family, social networks, education, employment and drug use. Each heading was fleshed out with a series of points intended as prompts to secure more detail, for example, under the heading 'Initial drug use' the prompts included how and where drugs were first accessed. The schedule was extensive which had a knock-on effect on the duration of the research study as interviews, transcription, coding and analysis took much longer to complete than anticipated.

⁷For example, in this respect I found the work of Ryan (1998), noted earlier in the Literature Review, to be useful in terms of his location of social exclusion in the breakdown of socially integrative mechanisms viz. the Labour market (jobs and income); the State System (access to education, health, housing and social services); and the Family and Community System (social

Even in retrospect, it is difficult to see how this could have been avoided as information was need on each topic to try piece together, what Mason (1996, p120) terms the "intellectual puzzle".

Entering the field

Field research, as I discovered, is a highly unpredictable experience. Arguably, this is even more the case when the research concerns users of illicit drugs, who (by virtue of their involvement in illegal activities) tend to be 'hidden' populations with corresponding erratic lifestyles. Consequently, attempts to capture their lived experience necessitated adopting a flexible approach to the research process so as to accommodate and respond to the contingencies that arose during my fieldwork.

In a previously published paper on my fieldwork (O'Gorman 2001), I suggested that it was useful to distinguish between the macro and micro environmental contexts which shape the fieldwork process. For while the latter may be dealt with by developing strategies regarding sampling, access, and fieldwork relations; contingencies which arise due to changes in the macro environment (i.e. the wider social, political and cultural climate) largely tend to be beyond the influence of the researcher and, consequently, the research design may require modification in order for the study to proceed.

The macro environment context

In the summer of 1996, just as the fieldwork for this study began, Dublin was seen to be experiencing the peak of a heroin epidemic (O'Gorman 1998). Dealing and using scenes were highly visible in a number of marginalised neighbourhoods and at key city landmarks. This 'junkie' presence on the city's streets was rendered even more visible by the media focus on drug-related crime, which contributed to a moral panic about the use of illicit drugs. A panic further exacerbated by the murder in one of the heroin neighbourhoods of a small time user-dealer, by a group of people who had earlier attended an anti-drugs meeting in the area, and a month later by the murder of a journalist investigating organised crime and drug trafficking.

networks).

At a community level, local campaigns were instigated to establish street patrols and organise mass marches on dealers' homes in their efforts to break up local drugs markets and encourage those involved in the drugs trade to reform or leave the neighbourhood. Some of those involved in the campaigns took more direct action, meting out vigilante style punishments to those suspected of dealing drugs within the community. The totality of these events had an immense impact on the communities involved, adding additional tension and fear as communities divided over how best to respond to the situation.

While the community sector worked on the ground to provide treatment services for the heroin users and try and maintain equilibrium in the neighbourhoods. The statutory services, heavily influenced by the moral panic over drugs and crime and the community campaigns, responded not just with additional drug treatment services but with a raft of criminal justice legislation and special police operations to tackle drug-related crime.

As a result, Dublin's heroin users became a population under siege, and targeted by the addiction services, the criminal justice system and from within their own community, they by and large disappeared off the streets and into hiding, treatment, or prison.

In turn, these events had a number of unanticipated effects on my research plans.. With the heroin users gone to ground, my plan to access heroin users in their natural habitat had to be modified as I found the users jumpy and suspicious and reluctant to engage in even casual discussions regarding the research. After a number of failed attempts at engaging the interest of the heroin users in the study, both with the aid of outreach workers and 'cold calling' users at drug scenes, I decided to adapt my strategy to suit the prevailing mood.

Modifying the research strategy

"No matter how carefully one plans in advance, research is designed in the course of its execution"

Becker's (1965, p602) comment seems particularly apt for ethnographic researchers who often find the best laid research design severely tested by the contingencies thrown up during fieldwork. However, when such contingencies require modifications to a research design, as in my case, I was mindful to ensure that any modifications I made were methodologically consistent and not just implemented on an *ad hoc* basis, or as an opportunistic response to an unforeseen situation - this latter point being a methodological criticism often levelled at Liebow's (1967) *Tally's Corner* when the initial research design was abandoned to follow the opportunity presented by his serendipitous meeting with 'Doc'.

Consequently, I adapted my initial strategy of using the contacts established through the key informant interviews to move into the heroin neighbourhoods to collect observation data and conduct in-depth interviews. In contrast, the modified strategy was to use *sites* rather than street scenes to access and interact with the research participants.

Sampling

Three main sampling strategies were employed during the research study, the first concerned the selection of neighbourhoods with active heroin scenes; the second, the selection of research sites as access points to the heroin users; and thirdly, the selection of the research participants.

Selecting the neighbourhoods

The sampling strategy for choosing which neighbourhoods to study was developed, in the first instance, from my list of areas with a known high prevalence rate of (treated) opiate use and a high level of socio-economic disadvantage. In choosing my sample, I also sought to capture a mix of areas such as suburban neighbourhoods with relatively new drug scenes as well as the more established scenes in the inner-city areas. In the end, the final sample of areas chosen was, by and large, opportunistic in that it was based on contacts I had made during my initial information interviews with key informants. However, my choice was also influenced by serendipity and being in the right place at the right time. For example, an introduction to a respected community activist in one area resulted in her facilitating my access to members of the local

community to a degree that would otherwise not have been possible. The ethnographic data I gathered in this area (Eastown) was particularly rich in terms of enabling my understanding of the interaction between the individual, his/her family and their local community, particularly with regard to socio-economic exclusion and problematic drug use.

In all, I selected five heroin neighbourhoods so as to cover a range of socially excluded *locale* – old inner-city areas; new suburban estates; and a high-rise flat complex. In retrospect, the number of neighbourhoods was large and some became more familiar stomping grounds than others. However, through this multi-neighbourhood approach I hoped to be able to make broad connections between the issues that arose in these areas. In so doing, I had been influenced by Agar (1996, p12) who, on realising the kind of data he wanted wasn't in any one community but scattered all over, decided "to make a pick and pluck at the details of everyday life" in several different locations so as to make explicit the ties that linked them.

I had considered whether I needed a control site to use as a comparison to the drug scenes in the disadvantaged neighbourhoods. However, I decided that it was futile to study a neighbourhood with nothing happening in terms of visible drug scenes. And as I lived at that time in a resolutely upper middle-class neighbourhood, I felt my observations on every day life there could serve as a counterpoint to life in the disadvantaged neighbourhoods.

The ethnographic aspect of this study sought to observe daily life and the drug scenes in a number of areas. This involved familiarisation with the areas, walking around, calling into the houses of people I had been introduced to, hanging around the local community centres, watching what was happening, listening to what was being said, asking questions and collecting accounts through informal interviews.

My aim was to observe daily life over an extended period of time. However, in the context of that time, with heroin users targeted by the police and local anti-drugs campaigns, it was difficult to locate and interact with the heroin users in these areas as strangers were treated with deep suspicion. As a result, observation sessions in these areas at night and weekend were kept to a minimum. Indeed most often there was no available transport to the areas as neither buses or taxis would travel into

some of the estates as drivers were fearful that their vehicles would be attacked and intercepted as they passed through.

Further details and an analysis of the five neighbourhoods are presented in the following chapter on *Neighbourhood Context*

Selecting the research sites

The use of agency sites as a means of accessing and recruiting drug users has been an important tool for researchers (for example Pearson *et al.*, 1987; Parker *et al.*, 1988). For this study, I intended to use such sites as an access point where the heroin users could be contacted and interviewed and also hoped that within these environments I could develop rapport with the users and hopefully snowball out into their natural setting.

I was, however, concerned that in choosing these sites that I avoided an over-reliance on drug treatment agencies. Drug users in treatment, and/or in touch with helping agencies represent a particular sample of the drug-using population, often reflecting the availability and nature of treatment services in an area. Generally, they tend to be older, male and former, rather than current, heroin users - hence their experience and information regarding drug scenes tends to be retrospective. In addition, as noted by McKeganey and Barnard (1992), in such settings researchers tend to see only individuals whose drug use is problematic rather than those for whom drug use is only one aspect of their lives. As a result, I identified a number of sites where I could access the heroin users and which I hoped would provide me with as broad as possible a representation of the heroin using population.

Contacts with key informants enabled me to draw up a list of research sites which would provide access points to the heroin users in the five neighbourhoods; these included community, youth and employment training centres, as well as drug services. In addition, I decided to try maximise the opportunity for interviews by accessing sites where heroin users from all of the neighbourhoods might congregate. These included prisons, the city's district courts (which dealt with most drug-related offences), homeless hostels, needle exchanges, drop-in centres, and a range of drug services with citywide clientele.

The sites were then selected from this list on the basis of judgemental and opportunistic factors - that is that the 'gatekeepers' were able and willing to co-operate, and that the site itself had the physical space necessary to conduct the interviews in private and ideally would also have a layout (for example seating/coffee/smoking areas etc.) that gave scope for interacting with the heroin users. These criteria were established through the interviews with the key informants which was where my fieldwork began.

Conducting the fieldwork

The fieldwork began in the summer of 1996 and was completed sixteen months later at the end of 1997. The fieldwork began with a series of information interviews with over forty people working in drug and community services such as psychiatrists; addiction counsellors; GPs; officers from the probation and prison services; politicians; social, community and youth workers; and other researchers and activists in the field (see Appendix 6 for list). These contacts were sourced through a variety of methods; many were suggested by colleagues at the drugs research unit where I was based, others were identified from the file of drug-related newspaper cuttings the unit collated; and as I met with each person I asked for further referrals. Initial contact was made in writing requesting a meeting and including a flyer describing the purpose of the research. Access to these key informants was relatively easy to secure as for the first two years of the research study I was funded by and based in a semi-state body (The Health Research Board) which was known to most, and where not known, sounded sufficiently official for these key informants to agree to meet.

The interviews with the key informants were intended to provide contextual information on issues relating to drug misuse in Dublin, as well as a means of accessing the research population. The data from these discussions was not recorded in a systematic way but points of interest were noted in my research diary and used to inform the development of the interview schedule with the heroin users and the coding and analysis of the interview transcripts.

These interviews also provided interesting insights into the prevailing views on drug use and research. Overall, problem drug misuse tended to be viewed as either a psychological issue associated with 'dysfunctional' families or as a class and poverty

related issue. Interestingly, these opposing, albeit often overlapping, views tended to divide along the lines of statutory and community based workers and reflected the response offered by their agency i.e. either structured medical and psychiatric treatment or community development approaches. During these discussions, I also encountered some reservations about the nature of my research study; for at that time the dominance of positivist research methodologies resulted in a tendency for qualitative research to be dismissed as anecdotal and subjective and, by and large, misunderstood. For example, after one lengthy explanation of the research methodology I was flummoxed to be asked if the data would be "statistically significant". In another memorable incident, my motives for recording the heroin users was queried, as their capacity to engage in meaningful conversation was doubted.

Negotiating access

The key informants whose services were located in or served the neighbourhoods with high levels of heroin use, were asked if they would be willing for their organisation to be included as a research site. None of these 'gatekeepers' gave an outright refusal. However, a number were reluctant to give an immediate commitment and despite contacting them again later, as requested, I was unable to secure a firm arrangement and eventually they were dropped from my list of possible sites. A number of other sites were ruled out, as there was no free space where I could interact informally with the heroin users. Ten sites were subsequently selected as access points, the number of interviews each yielded is illustrated in Table 3.1 (over).

The process of negotiating access to the research sites did not just entail dealing with the gatekeepers. Staff members, at a number of levels in the agencies and services had to be briefed on the research and their support elicited. And as I discovered, these were often the most crucial alliances I had to forge. While managers and senior staff may have granted me official access to a site, this did not imply that those working on the ground would comply or be helpful. As a result, I found the time spent building a rapport with front-line staff paid off in terms of their willingness to introduce me to the heroin users and to vouch that I was 'sound'.

However, even after securing 'access' with both management and frontline staff I could not assume that the heroin users would be willing or interested in participating in the research. At that point I considered it best to distance myself somewhat from the staff so that I was seen to be working independently. For I considered that the heroin users would feel freer to be interviewed and have less concerns about confidentiality if I was not seen to be too closely associated with the management - a difficult tightrope to tread! Consequently, after I was introduced to or approached by the heroin users, I then had to engage in a further negotiation process with them, explaining the nature of the research and asking if they wished to participate.

I found these explanations to the heroin users the most challenging as my academic pursuit seemed grossly removed from the realities of their everyday lives. However, over time, I learned to develop user-friendly accounts of the study for different situations. And most often I found, as had Shaffir (1991, p78), that it was better to play down my academic status, and to eliminate the word sociology from my vocabulary as this "seemed to confuse more than clarify".

Table 3.1: Research sites and respondents

| | Research site | Catchment area | N. & gender of interviewees | Age range |
|----|--|-----------------------|--|------------------|
| 1 | Institution for young offenders | All areas | 12 Males | 17-20 |
| 2 | Drop-in for drug users | Northtown | 2 Males | 24-29 |
| 3 | Statutory drug treatment centre | All areas | 4 Females 6 Males | 20-43 |
| 4 | Community centre | Easttown | 2 Females 1 Male | 29-40 |
| 5 | Residential therapeutic centre | All areas | 4 Females | 15-31 |
| 6 | Statutory drug treatment centre | Talltown | 3 Females 2 Males | 20-33 |
| 7 | Homeless hostel | Talltown | 1 Male | 19 |
| 8 | Training programme for stable drug users | All areas | 3 Females 4 Male | 19-31 |
| 9 | Community based treatment centre | Westtown | 5 Females 6 Males | 16-28 |
| 10 | Youth training scheme | Northtown | 6 Females | 17-24 |
| | TOTAL | | (27F; 34M) 61 | 15-43 |

Sampling within sites

As there had been a number of levels in the process of negotiating access, so too were there layers in the sampling process where not just the sites but also the heroin users within the sites had to be sampled.

The sampling strategies employed varied from site to site. In some sites the gatekeepers themselves selected the research population, while in others I had access to all the drug users and could sample appropriately. In the latter case, wherever possible, the heroin users were randomly sampled to try and compensate for the lack of randomness involved in the opportunistic/purposive sampling of the sites. For example, in selecting the research participants from a prison population, the name of every tenth prisoner was chosen from the list of inmates provided and that person approached if they were from one of the selected neighbourhoods. One further stipulation I made was that, overall, the sample was to be gender balanced to avoid the tendency in drugs research for male views and male behaviour to be taken as representative of the drug-using population (see Taylor, 1993).

While half of the ten sites were involved with drug treatment and half of the research population were recruited at these sites, it transpired that many of my respondents turned out to be undergoing some form of treatment. Spending time to recruit respondents from non-treatment sites only to discover during the course of the interview that they were in treatment, or self-treating with Methadone bought on the streets, was hugely frustrating. However, some of these were also currently using heroin despite being in treatment (see Chapter 5 for further details of the interviewees drug use).

The in-depth interviews

One of the first information interviews I conducted was with the governor of an institution for young offenders who proved to be a particularly helpful informant. This factor, coupled with the attraction of having a 'captive audience' for the first series of interviews, led to my using the institution as my first research site. Even though, this site had little possibility of yielding contacts with heroin users in their neighbourhoods, in retrospect, this choice was unintentionally inspired as my

experience in the prison gave me a certain cachet with later respondents many of whom had family and friends detained there.

Overall, during the sixteen months of fieldwork, sixty-one in-depth interviews were conducted with heroin users. This was less than the hundred I had targeted but as this had been an arbitrarily picked number I had little hesitancy in stopping when time ran out as I felt I had reached data saturation at this point.

These in-depth interviews lasted approximately one hour and were loosely structured around a set of themes and topics concerning the respondent's drug-using career and experience of localised social exclusion, as outlined in my earlier discussion on developing the *aide memoire* (see also Appendix 2).

While each topic was introduced in the course of the interviews, the emphasis and detail given to each issue was left to the respondent. For in seeking to understand the social world of the problem drug user, I felt it was important to allow the respondent to direct the flow of the conversation to what they perceived were the key issues and to keep my input and direction to a minimum. As a result, I decided not to conduct pilot interviews, which had been part of my intention in starting in the prison setting, but to use each interaction with the heroin users as data. In addition, in the spirit of ethnographic research, I made every effort to minimise the hierarchical structures associated with interviews. For example, I provided coffee, biscuits and cigarettes and, where possible, arranged the seating in the room to provide a relaxed atmosphere in order to make the interview as similar to a naturally occurring conversation as possible.

While many of the interviews took place at the access sites, a number of the heroin users I got to know over time invited me to their home to conduct the interviews; another couple of interviews took place in local cafés. It is difficult to assess whether these different settings impacted on the interviews. All but one of the interviewees (one of those conducted in prison) were open and vocal on the issues we discussed. Many related afterwards that they had enjoyed the process as it was the first time they had spoken to someone about their lives and drug use where the listener was

non-judgemental and the focus of the interaction was other than interrogation or rehabilitation.

Research ethics

At the time I conducted the fieldwork, little ethnographic or qualitative research had been conducted in Ireland and there were no ethical guidelines regulating this type of research. However, based on my research experience in the UK where ethical considerations had been a priority,⁸ I was conscious of the ethical implications of my work and so took counsel from the British Sociological Association's guidelines.

I saw the ethical implications of my work as having two connecting strands. One, in relation to the confidentiality of the data I was collecting, the other in relation to the ethos and spirit in which the study was undertaken and the recognition of the more powerful position I held compared to that of the research subjects.

With regard to confidentiality, although I knew each respondents name, I asked permission to record their name for follow up purposes and all of them did so willingly even though they were reassured that they were not obliged to do so. This data was recorded separately from the interview data with a coded number linking the two items, the only identifying data recorded in the interview were the respondent's age, gender and area of residence. Respondents were assured of the confidentiality of their interview material although this did not appear to be of great concern to them. All of the interviews were recorded, but only following the respondent's consent.

In terms of securing the interviewees informed consent, before each interview began I explained how and why I was carrying out the research and what the data would be used for. I encouraged respondents to ask questions to ensure that they understood what I had said and that they were fully informed about the study and also because it helped to get a conversational style going and for the interviewee to relax. In addition, I decided to anonymise the neighbourhoods in which the

⁸ This was particularly true for the ethnographic research I conducted while at the Centre for Urban and Community Studies (CUCR) in Goldsmiths College, University of London.

ethnographic work was conducted for two key reasons. First, I was concerned that identifying the areas would add further stigma to those who lived there and, secondly, as the areas were publicly conceived as 'problematic', I wished to avoid readers' pre-conceptions of the areas clouding their judgement of the issues and viewing them as specific to the areas studied rather than relevant to excluded places in general. The names of the heroin users were also changed to avoid them being identified.

In terms of the spirit and ethos of the research, the research questions and the method were designed to ensure that the views and sensitivities of the heroin users were prioritised. Little qualitative and ethnographic research had been conducted, at that time, with heroin users in Dublin and I hoped to give voice to a group who were silenced and marginalised in our cultural story by telling, what Richardson (cited in Miller and Glassner, 1997, p104) terms 'collective stories' which challenged the existing stereotypes of heroin users.

I was also mindful of Bourgois' (1999, p10-11) rather scathing view of researchers who manage to become experts on drugs without ever having to interact with drug users in their problematic, dangerous and uncomfortable indigenous environments. And while the ethnographic component of my study was one of a number of methods, I did seek to engage in non-judgmental, culturally relative interaction with the heroin users in their neighbourhoods. Furthermore, by locating their narratives within social and structural contexts, I sought to ensure that the accounts of their daily lives would not contribute to what Bourgois calls "exotic voyeurism" (*ibid*, p11) that demeans the socially vulnerable.

Presentation of self

Throughout the fieldwork, I was conscious of how my 'presentation of self' influenced and shaped relationships in the field, and as a result, the qualitative data that was collected.

In terms of appearance, the clothes worn during fieldwork can be a simple tool for, what Hammersley and Atkinson (1995, p87) refer to as, "the construction of a

working identity". However, thankfully, it was not always necessary to go so far as Patrick (1973, p15) and don:

a midnight blue suit, with a twelve-inch middle vent, three-inch flaps over the side pockets and a light blue handkerchief with a white polka dot (to match my tie).

Instead, I followed the advice given by Power (1989) to blend-in but not to overdo things. However, my version of blending-in turned out to be quite different to the logo-ed sportswear worn by the younger folk in the neighbourhood and the 'no-name' brands of their elders. In retrospect, it was probably better to stick-out rather than be suspected of duplicity, for as Fetterman (1991, p89) notes, people have "emotional radar" to spot fraud and insincerity and "natives can identify an outsider immediately, by the stranger's clothes, speech, complexion, and even mannerisms".

While some research literature contends that access is more likely if cultural and ascriptive differences (such as class, race and gender) between the researcher and the researched are minimised, this is not invariably so. Nonetheless, I found it useful to follow Liebow's (1967) recommendation to dull my (middle) class characteristics. Conversely however, it was sometimes useful to accentuate my rural origins and to make a self-deprecating remark about being a 'culchie'⁹ as an ice-breaker in awkward situations. I also found that as a female researcher it was relatively easy to build rapport with female drug users and also to present a non-threatening persona to male drug users.

The seemingly effortless ethnographic task of 'hanging-out' was, as I discovered, much more difficult to achieve than I had expected. In the first instance, this necessitated adopting a confident but easy going manner, even though I often felt apprehensive and nervous, so as to develop a level of rapport with the research participants. Hanging-out also required a combination of patience and timing. For example, through trial and error, I developed a sense of when it was appropriate to approach someone and engage them in conversation and when it was best to leave someone alone, as well as learning that it is not always advisable or necessary to be pumping for information. Indeed, often, as advised by Polsky (1967, p121), I found it best to "keep your eyes and ears open but keep your mouth shut".

⁹ Culchie – a nickname used by Dublin people to describe people from rural areas.

Later, as field relations developed, I found myself striving to maintain a balance between keeping an open and friendly manner and becoming a 'marginal native' so as to preserve my critical perspective and ensure that research situations continued to be rendered 'anthropologically strange'. For as Hammersley and Atkinson (1995, p115) caution, "the comfortable sense of being 'at home' is a danger signal" for the fieldworker.

Methodological Issues

Multiple data sources

The use of multiple data sources, as described earlier, is not without methodological complications. Triangulating data from different sources is, for example, viewed by Silverman (1985) as a methodological contradiction for research conducted within an interpretivist paradigm in that it implies that partial views can simply be added together to produce a complete picture, and is thus based on the (positivist) assumption of multiple mappings of a single reality. However, while attempts to adjudicate between accounts/data gathered in different settings may indeed fall into this methodological trap, there is a plausible case to be made for understanding each account in the context in which it was produced, and for such accounts to mutually inform each other (see Bourgois, 1999).

Using multiple data sources to explore the social exclusion-heroin use nexus was additionally useful in ensuring that the relationship between individual lives and social structure was not sidelined (Brückner, 1995) and that respondents' meanings and experiences were located within social processes and structural forces. Without such multiple sources, the study ran the risk that its focus on 'the underclass' would reinforce "the received wisdom that it is in such groups that the 'problem' is to be found" (Hartnoll, 1992, p16).

In addition, the multi-method approach allowed for what Agar (1996, p37) termed the "massive over-determination of pattern", that is, if the pattern is validated by several different types of data then it exists, no one can make it go away. Indeed, current debates on drug risk behaviour have begun to address the need to

investigate the complex interplay of 'macro' and 'micro' influences on drugs behaviour through the use of multi-method studies. (cf Rhodes, 2002)

Validity and reliability

The concern of qualitative researchers with traditionally positivist issues of data validity and reliability often seems to sit uneasily within what Guba and Lincoln (1994, p110) term a 'subjectivist' epistemology. Nevertheless, some qualitative researchers, somewhat defensively, appear unable to shake off the positivist ghosts of validity and reliability and continue to argue the methodological toss. For example, Kirk and Miller (1986) and Silverman (1993) find the issues of validity and reliability important because in them the objectivity of research is at stake. While it is crucial that the findings are "independent of accidental circumstances of the research" (Kirk and Miller, 1986, p20) and that accurate descriptions of the social world are produced, the desire for *data integrity* seems more in keeping with the interpretivist paradigm. In this respect, for me the multi-method approach which allowed for a comparison of data from a number of sources helped verify the integrity of my findings.

In addition, it was useful to bear in mind Miller and Glassner's (1997) contention that qualitative research cannot provide a mirror reflection of the social world that the positivists strive for. However, at its best it can provide access to the meanings people attribute to their experiences and social worlds. Furthermore, they claim that while the interview "is itself a symbolic interaction, this does not discount the possibility that knowledge of the social world beyond the interaction can be obtained." (*ibid*, p100)

Data analysis

As Silverman (1993) describes, interviews are traditionally analysed as more or less accurate descriptions of experience or representations of reality. Accordingly, analysis should entail systematically coding, grouping or summarising the descriptions and providing a coherent framework for analysis. In seeking to do this, my analytic objective was not merely to describe 'the situated production of talk', but to show how what is being said relates to the experiences and lives being studied. In

preparation for this data analysis, the tape-recorded interviews with the heroin users were transcribed in full; this took on average about eight hours per hour of recorded conversation. The result was a large volume of textual data which required a systematic approach in order to build up an inductive analysis. To assist with this I used the software package *The Ethnograph* to help code and sort the textual data in preparation for analysis.

To code the data, each transcribed interview was reformatted and imported into *The Ethnograph* software programme. These interview texts (which run from between 30-60 pages) were then printed out in a special format where each line of text is numbered. Using the headings and sub-headings from the interview schedule as an initial set of codes, I selected six scripts, from male and female respondents equally, to further develop my coding frame. The numbered texts were closely scrutinised and segments identified and marked with one or more code words to signify the themes they represent. When all possible codes were identified in the test scripts, they formed the basis for the coding frame I then set up in *The Ethnograph* (see Appendix 3). Each text was then coded manually by applying the relevant code to the appropriate section of the text, after which the line numbers of each coded section of text were entered and allocated their code in the software package. The complete dataset of all the scripts was then sorted into the themes for which they had been coded and printed out thematically so that, for example, all data relating to employment could be examined together and the issues relating to this theme identified.

This coding process was extremely time consuming and took about four months work to complete. For in order to ensure the integrity of the data, the code words had to be applied consistently throughout the texts so that every instance of a theme was identified and coded. Despite the length of time the coding took, this process ensured that the subsequent analysis of the large dataset was based on themes and issues which had been systematically collated. The data relating to each theme were read and re-read until I was satisfied that I had grasped the meaning of the data and that I had identified the issues emerging. Each theme was thus gradually developed on an inductive basis with relevant quotes selected from the material to support and clarify the analysis.

In writing up the data chapters, data from the ethnographic studies and the quantitative data on social exclusion were used to contextualise the primary interview data and to provide points of comparison. In addition, a number of quantifiable variables were identified in the transcripts relating to the heroin users drug history and personal lives. These variables were entered into an SPSS database to provide a profile of the heroin users and their drug-using careers. These data are presented in Chapter Five as a representation of the heroin users interviewed for the study.

Conclusion

As described in this chapter, this study was designed to capture some of the complexity indicated in the literature review as to the dynamic nature of local drug scenes and the structural forces and social processes which influence them. Using both quantitative and ethnographic data to provide a contextual framework, the emphasis is nonetheless firmly placed on the lived experience of the heroin users resident in the socially excluded drug neighbourhoods. In the subsequent data chapters the outcome of this method and methodology is presented. First, the neighbourhood context is examined, then the development of the heroin users' drug careers and the impact of the local drugs market. These chapters are then followed by an examination of the heroin users lives in terms of their education and employment experience, their family lives and their attempts to disentangle themselves from their drug careers. To conclude, the final discussion chapter seeks to tie these interconnecting strands into an inclusive, theoretically based account of neighbourhood dynamics.

Chapter Four

The neighbourhood context

Introduction

This first data chapter describes and provides a social analysis of the five neighbourhoods which were home to the heroin users who participated in the study. Each of these neighbourhoods was selected on the basis that residents experienced both high levels of socio-economic disadvantage and localised drug problems; the latter characterised by extensive problem drug use among its inhabitants and a visible drugs market.

The aim of this chapter is to provide a holistic picture of the lived experience in the neighbourhoods. Section One examines the demographic and socio-economic data for each neighbourhood from the 1996 Census, the year the fieldwork for this study began. This is supplemented with data and analysis from local development bodies and relevant literature. Section Two expands on these issues through a qualitative and descriptive analysis of the areas based on residents' narratives and my own ethnographic observations. Throughout the chapter, emphasis is placed on identifying the key issues in terms of the commonalities and differences that appear to be most significant in the neighbourhoods.

Background

Dublin neighbourhoods have traditionally been characterised by a high level of class segregation in that public housing has been provided by local authorities *en mass* in enclaves around the city, mostly in the form of sprawling suburban housing estates and inner-city flat complexes which are relatively isolated from their middle-class counterparts and the commercial areas of the city.

The economic recession which began in Ireland in the late 1970s, intensified in the 1980s and tailed off in the mid-1990s, impacted disproportionately on working-class communities as their traditional industries folded due to economic restructuring and monetarist economic policies which led to soaring unemployment rates. In addition, during the 1980s and 1990s housing policies and practices, such as an under-supply

of public housing and its allocation on a 'points system', resulted in a concentration of people with the greatest social and economic needs being housed in areas with little support structures in place. Indeed, Nolan and Whelan (1999) found that the percentage of urban local authority tenants in poverty increased markedly from 48 per cent to 62 per cent between 1987 and 1994. In addition, the socio-economic situation of these households deteriorated to the point where just over three-quarters (76%) had no educational qualifications and two-thirds (66%) were unemployed, over half (55%) of whom were long-term unemployed i.e. for 12 months or more.

Section One: A comparative neighbourhood social analysis

The five Dublin city neighbourhoods to be examined vary in a number of respects. Two are old working-class neighbourhoods in the inner city that were part of the larger area blighted by the city's initial heroin epidemic in the early 1980s. One is a high rise 1960s flat complex located close to the city centre. The remaining two are local authority housing estates built in the 1980s on the periphery of the city.

Census data

The only comparable area-based data available to conduct a systematic and comparative social analysis of these neighbourhoods are that provided from the population census returns for District Electoral Divisions (DEDs). Yet, many of these DEDs are based on ancient boundaries that have long since lost their significance and may not correspond with what local residents identify as their neighbourhood. For example, a DED may cover only part of a flat complex or an estate or may contain a number of streets perceived as belonging to a different neighbourhood. Consequently, not only do DEDs frequently represent artificial constructions of a neighbourhood, but also data on pockets of poverty within a DED may be statistically diluted by more prosperous neighbours living in the vicinity.

In addition, as the area and population size of DEDs are not consistent, population density rates vary considerably from area to area. Accordingly, the data expressed as a percentage of the local population, while facilitating comparisons, do not always capture the concentrations of social phenomena in neighbourhoods. For example, the

same unemployment rate in areas of high and low population densities do not fully reflect the critical mass of people affected.

Furthermore, while no compliance rates for completion of Census forms are published, it would seem, based on conversations with residents during the course of this study, that inhabitants of poorer neighbourhoods are less likely to complete these forms, and as a result their experience may be under-represented in the data. In addition, as the Census is conducted for mostly administrative purposes the data collected is not always the most indicative of sociological phenomenon.

Despite the above caveats in relation to the Census data, these are the only comparable data available which can provide an insight into the demographic and socio-economic context of the five neighbourhoods. Consequently, in my analysis I adopt a critical approach to the data and use the ethnographic data I have collected as a way of surmounting these limitations. The data tables accompanying this discussion are presented in Appendix 4.

Socio-economic and demographic profile

The socio-economic and demographic variables examined in this background study are those which have been consistently identified in Irish literature as being characteristic of social deprivation and exclusion (see for example, Gamma, 1998a-d; Fahey, 1999; Nolan and Whelan, 1999; Pringle, Walsh and Hennessey, 1999). Such variables include demographic data on population density (expressed as the rate of persons per square mile); age range and the rate of population change; data relating to household composition; as well as socio-economic indicators such as education levels, employment rates, income and social class.

Among the key issues examined are rates of early school leaving which in the Irish context relate to those who left school at or below 15 years of age. And as a counterpoint, the rate of local people with a third level education. This latter point may indicate the level of social mix in the area as third level education has, in Ireland, largely remained the preserve of the middle classes (see Clancy, 1995; Drudy and Lynch, 1993).

In terms of identifying the level of unemployment in the neighbourhoods, I was conscious of how the definition of unemployment rates may be politically constructed by, for example, not including those who are on government training schemes. As a result, I also examined the rate of those who were in work in order to estimate the extent of what Wilson (1987) terms 'joblessness' i.e. those who are not participating in the labour force as well as those who are unemployed.

There was no data on housing tenure available from the census data which would have been useful information as the interrelationship between tenure, class and disadvantage has been well established in Ireland (Fahey, 1999; Nolan and Whelan, 1999). Nonetheless, all five neighbourhoods were predominantly public housing areas with little or no privately owned homes, managed by the housing authority for the city.

Social class in the census is determined by the occupation and employment status of the head of the household. In the accompanying tables to this chapter I have included data at the extreme levels of this scale i.e. Social Class 1 (professional workers) and on Social Class 5, 6, and 7 (respectively, the semiskilled, unskilled and the unclassified occupations). This latter classification is most revealing as it includes those who have never been in paid employment or live in a household where the head of the household has never been in paid employment.

In the section that follows, these key variables are examined for each neighbourhood and later are analysed comparatively in order to identify the commonalities and differences both between the DEDs and with the overall Dublin Region figures which serve as a reference point for relative comparison.

The Neighbourhoods

The names of the five neighbourhoods examined in this study have been changed to mask their identity. Despite doing so, many readers with a knowledge of Dublin will probably recognise the areas and if not the bibliographic references may hint at their location. Nonetheless, I believe that it is useful to avoid naming the areas directly in order to focus on the issues which may be common to socially excluded places in general.

Northtown and Southtown

Northtown and Southtown, are old working-class neighbourhoods in the inner city. Housing in both areas predominantly comprises of public flat complexes built during the 1950s and 1960s. Both areas are regarded as having similar experiences of housing and socio-economic policies (see Butterly, 1999; Fahey, 1999). For example, during the 1980s, incentives to develop the city's suburbs through the creation of new towns on the periphery contributed to the neglect and physical decay of these areas. In addition, the loss of traditional industries during the economic recession of the 1970s led to a contracting job market for the less skilled and high concentrations of unemployment (National Economic and Social Forum, 1981).

Both areas also share a similar history in terms of their experience of localised drug problems. The first epidemic of heroin use in the early 1980s settled in the local authority flat complexes in these neighbourhoods and the surrounding areas (O'Gorman, 1998). In community studies carried out at that time, approximately 10% of the 15-24 year age group in these areas were reported to be using heroin (Bradshaw, 1985; O'Kelly *et al.*, 1988).

In 1996, the neighbourhoods of Northtown and Southtown were still largely immune to the new urban renewal programmes in the inner city and the emerging economic boom. If anything, poverty and drug problems appeared even more concentrated and entrenched within these micro areas. For example, Corcoran (1998) found 91% of the adult residents on an estate in Southtown to be reliant on social welfare benefits of some type.

Despite a number of community-based, anti-drug, campaigns, police operations and the introduction of drug treatment services, albeit quite limited at this point in time, the sale and use of drugs in the area has continued and at the time of the fieldwork was once again at a point of high visibility. In both areas, the open sale and use of drugs were concentrated in the public housing flat complexes and in adjacent streets. For the year 1996, Comiskey (1998) estimated an opiate prevalence rate of 175.7 per thousand males aged 15-24 in the greater Southtown postal area, and 148.6 per thousand males in the greater Northtown postal area; these were, respectively, the highest and second highest area rates in the city.

Northtown is a densely populated area of approximately 5,000 inhabitants and an average density of 25,000 people per square mile (Table 4.1). As over a third (35%) of the population are aged between 15-29; this corresponds to almost 9,000 young people per square mile (Table 4.1). Almost three-quarters of the population (72%) in one DED are early school leavers, nonetheless 10% have a third level education (Table 4.2). In the same DED, one in four adults are in work (24%), almost two-thirds (63%) of the men are unemployed and almost three-quarters of these (72%) have been so for more than three years (Table 4.3). Over half (53%) of the women are unemployed (Table 4.3). As a result of these high levels of joblessness, a high proportion of the population, almost every second person (43%), belongs to the 'unclassified' social class, whereas one in forty (2.5%) residents are 'professional workers' (Table 4.4).

Southtown, has a population of just under 4,000 people (Table 4.1). Although the area contains two large local authority flat complexes, it has a more mixed tenure than its counterpart in the north inner city. Nonetheless, one of the DEDs has the highest population density of the five neighbourhoods at 31,000 people per square mile (Table 4.1). Similar to Northtown, the density of young people in the 15-29 age group works out at approximately 9,000 per sq. mile (Table 4.1). One in thirty-three people (3%) are professional workers whereas one in four (22%) are designated as unclassified (Table 4.4). Half of the residents are early school leavers, while one in six (15%) have a third-level education (Table 4.2). Approximately one in three adults (35%) are in work, 40% of residents are unemployed, over two-thirds (68%) of men in the area who are unemployed have been so for more than three years (Table 4.3).

Talltown

Talltown is physically unique in the Irish context, being a high-rise flat complex which was built in the late 1960s on a green-field site in the then suburbs as an urgent remedy to the housing crisis of the time. Initially, the area was hailed as a modernist masterpiece of new urban living, however, social and recreational structures were never put in place and the area deteriorated physically and socially. The local authority remains the sole landlord for residents in the flat blocks most of whom are wholly reliant on social welfare for their income. Housing allocation policies have been identified as one of the contributory factors to the area's malaise. Power's

(1997) analysis of this 'estate on the edge' listed a litany of ill-conceived policies such as the large scale housing of lone parents, single people transferred from institutional care, and homeless families, which were seen to have a detrimental impact on the area. In 1987 (twenty years after the flat complex had been built), a local evaluation study demonstrated how the housing authority had used the estate as a dumping ground for its most at-risk tenants - 59% of all single people (many with mental health difficulties), 45% of all single parents and 28% of all homeless families housed by city's housing authority were placed in the area despite the estate accounting for just 10% of the public housing stock (BLDTF, 1997, p5-6).

Poor housing management added to the difficulties experienced by those living on the estate. The flat blocks were poorly maintained and communal areas and stairwells decayed over time. The lifts in the tower blocks were a recurring problem with an estimated one third of the lifts out of order at any given time (BLDTF, 1997, p5). The communal areas of the flat blocks were used as 'shooting galleries' with numbers of young people sleeping there and/or awaiting the arrival of the dealers (BLDTF, 1997, p14). The combination of all these difficulties was seen to contribute to a high level of turnover among the tenant population.

Figures from the 1996 census indicate that the area is home to approximately 15,000 people in 5,000 households – approximately half in flat blocks of four, eight and fifteen storeys and the rest in houses (Table 4.1). The area is compact, approximately two sq. miles, and homogenous. No huge differences exist between different parts of the area, although the flats are perceived as less settled than the houses with some flat blocks seen as worse than others (BP, 2003). Density levels in the area are high with approximately 20,000 people per sq. mile (Table 4.1). Just under a third (30%) of the population is in the 15-29 age group which corresponds to approximately 6,000 young people per sq. mile (Table 4.1).

Over half of the population (57%) are early school leavers; only four per cent have a third level education (Table 4.2). Not surprisingly given the low level of formal education, less than one per cent (0.7%) of the residents are professional workers; one in three (35%) of the residents belong in the unclassified social group (Table 4.4). One third of the adult population (34%) is in work; nearly one out of every two

people (43%) is unemployed (Table 4.3). Almost half (48%) of the men in the area are unemployed, and almost a third of these (62%) have been so for more than three years (Table 4.3). Over a third (35%) of the women are unemployed, of those who are working one in two do so in a part-time capacity (Table 4.3).

The drug problem that materialised in Talltown was regarded as being qualitatively different than in the inner-city areas in that it, initially, mainly consisted of the use of barbiturates, codeine-based cough bottles, benzodiazepines, and opioids whose popularity over heroin was seen to be related to the lack of a consistent supply of heroin in the area (BLDTF, 1997).

Widespread open drug dealing has long been a feature of the area (BLDTF, 2000) particularly around the almost derelict shopping centre. Few treatment facilities were available and, in 1995, 135 residents were recorded as being in receipt of methadone treatment (BLDTF, 1995). For the year 1996, Comiskey (1998) estimated an opiate prevalence rate of 48.4 per thousand males aged 15-24 in the Talltown area.¹⁰ A few years later, a local prevalence estimation study found 683 known opiate users in the area which translated into one in thirteen of the 15-49 year age group (Foxe, 1998).

Eastown and Westown

The remaining two neighbourhoods, Eastown and Westown, are situated on the periphery of the city. Both are relatively new developments which were built by the housing authority during the 1980s. The building density is low, the standard home being a three bed-roomed semi-detached or terraced house with a small garden to the front and rear. Houses in both areas are still mostly rented from the public housing authority. Infrastructure has been slow to be put in place and is limited to a school, church and a few shops. Little attention was given to the provision of cultural and recreational facilities contributing to their overall bleakness. Transport links are poor; the areas are isolated from the rest of the city and entail long bus journeys to reach the centre. Lack of transport also hampers employment opportunities as it

¹⁰ Comiskey's (1998) study used a three-source capture-recapture methodology to estimate opiate prevalence in Dublin for 1996. However, as one of the sources used was drug treatment data it is arguable that this method underestimates the figure for areas where services were less developed, such as Talltown, Eastown and Westown.

restricts the mobility of the residents. The new industrial zones established nearby are mainly in the technology sector and require skilled workers with a strong educational base (CP, 2002; NP, 2003).

Anecdotal evidence from key informants report that problem drug use is a relatively new phenomenon in these areas and one that revolves around the trend for 'chasing' rather than injecting heroin as is the case in the other neighbourhoods. The newness of this phenomenon is reflected in Comiskey's (1998) data which estimates a minimum number of 50.2 per thousand of the male population aged between 15-24 using opiates in the postal district where Westown lies and a lower figure of 21.6 per thousand in the Eastown area. However, at the time the fieldwork for this study was being conducted, the drug problem had reached a stage where heroin had come to dominate the minds and lives of those living in the neighbourhood.

Eastown has a population of just over 7,000 in 1,600 households, more than 4 people per house (Table 4.1). One of the DEDs has the highest proportion (33%) of lone parent headed households in all of the five neighbourhoods (Table 4.1). Density in one of the DEDs is particularly high, over 18,000 people per sq. mile with over 5,500 per sq. mile in the 15-29 year old age group (Table 4.1). The other DED has a substantially lower density rates but this is accounted for by the inclusion of large patches of, as yet, green spaces within the DED boundaries. However, with an average of 4.4 people per household in both DEDs the density within the households is higher than in the other neighbourhoods (Table 4.1).

Almost two-thirds (60%) of the residents have left school, at or below, the official school leaving age of 15; three per cent have a third level education (Table 4.2).

Less than one per cent of the population belongs to the professional social group; over a quarter (26%) are designated as unclassified (Table 4.4). Less than a third (31%) of adults are in work; almost half (49%) are unemployed (Table 4.3). The unemployment rate for males is higher (54%); and almost two-thirds (63%) of these have been long-term unemployed (Table 4.3). Over half (51%) of the women who work do so on a part-time basis (Table 4.3).

Westown has a population of just over 20,000 people in 5,000 households, consequently, density levels within the houses are as high as in Eastown (Table 4.1). Density levels within the DEDs are also high; one of the DEDs has the equivalent of 20,000 people per sq. mile, just over 6,000 of whom are in the 15-29 age group (Table 4.1). The two other DEDs have a lower density as about half of these areas are green-field sites, nonetheless those pockets which are inhabited have a similar layout and design and would have a similarly high density level to the other. One DED also includes a private housing estate in the far corner of the area which would further dilute some of the statistics, thus, for example this estate may account for the relatively high level (15%) of third level education in the DED (Table 4.2). Despite this, just under half (48%) of the overall population there are early school leavers (Table 4.2).

A minimal rate (1%) of residents are classified in the professional social group and, in comparison with the other DEDs, there are far fewer members (15%) in the unclassified social group (Table 4.4). Not surprising then that this area also has the highest proportion of people in work (44%) and the lowest level of unemployment (29%) (Table 4.3).

Commonalities and key issues

Having examined evidence from each of the neighbourhoods in turn, it is useful to compare and contrast the data from these neighbourhoods to check for similarities and possible interrelationships between variables. To further this analysis, additional data for the Dublin Region is used as a point of comparison.

Population and household data

Density levels varied considerably within the five neighbourhoods ranging from approximately 5,500 per sq. mile in one of the Westown DEDs to just over 30,000 per sq. mile in the Northtown area. However, even within this broad range the lowest density was substantially higher than the average figure for the Dublin Region (3,000 per sq. mile). The number of households within the DED areas also varied from 700 in one part of Eastown to 2,000 in a DED in Talltown. The average number of people per household ranged from two to five persons; the Dublin Region average

was three (Table 4.1).

A number of the DED areas had experienced considerable population change, both expanding and declining, since the 1986 Census. However, the rate of population change was not consistent in all areas and ranged from a decrease of 12% in part of Talltown to an increase of 22% in part of the relatively new suburb of Westtown and the inner-city area of Northtown, the latter probably reflecting the programme of urban renewal in part of the DED area. These rates were substantially higher than the Dublin regional average of 4%; indicating that these neighbourhoods had experienced a substantial level of instability and change in their population (Table 4.1).

The percentage of the population aged 15 to 29 years of age - the age group most likely to be heroin users and the age range of the vast majority of the research participants – varied within each of the neighbourhoods and averaged at about 30%, with one DED in the Northtown area considerably higher at 40%. Aside from this latter area, the rates were consistent with those of the Dublin region (27%). However, when density is taken into account, the number of persons aged 15-29 is over 5,000 per square mile for ten out of the twelve DEDs, over six times higher than the equivalent figure (817 per sq. mile) for the Dublin region.

The percentage of lone parent households in the DEDs varied, ranging from 11% to 33%; the average for the Dublin region was 11% (Table 4.1). There did not appear to be a pattern to these figures which is surprising as lone parenthood is a phenomenon associated with poor working-class communities in Ireland. However, areas with lower than expected figures would not include single parents and their children living in other households, such as their parental home, which may account for some of this discrepancy.¹¹

Educational disadvantage

In the Dublin region, a quarter of the population has had either no formal education

¹¹ The census records the number of lone parent households rather than the social phenomenon of lone parenthood.

or primary education only. In the five areas covered by this study, the rates are considerably higher ranging from 31% in a Westtown DED to 51% in a Northtown DED (Table 4.2).

Data on the proportion of early school leavers range from 36% to 72% in the five areas. Three DEDs have rates under or similar to the Dublin regional average of 49%; in the remaining DEDs, over half of those who have left school had done so before the official age of leaving. In contrast, the rates of those with third level education range from 2% to 20% compared to the regional average of 25%. Half of the twelve DEDs have third-level education rates of 5% and lower which combined with high levels of early school leaving indicate areas of severe educational disadvantage. These areas are almost wholly public housing areas which have been developed on green-field sites in the suburbs. The two inner-city areas have somewhat higher rates of third level education indicating a more mixed population (Table 4.2).

Social class

Data from the five neighbourhoods show that there is a markedly low level of professional workers (Social Class 1) living in the areas. Compared to the Dublin regional average of 7%, figures range from less than a half a per cent in an Easttown DED to 4% in Northtown (Table 4.4).

The proportion of semi-skilled manual workers resident in the five neighbourhoods is higher than the regional average ranging from 13%-22% compared to 12%. The level of unskilled workers is also higher; in nine out of the twelve DEDs the rate is at least twice that of the Dublin average. However, perhaps most revealing are the figures for the unclassified group, in five DEDs more than one in three belong to this social group cumulating in a rate in part of Northtown which is over three times the regional average, 47% compared to 13% (Table 4.4).

Joblessness

The level of unemployment in the neighbourhoods varied from 21% in a Westtown DED to 59% in part of Northtown – all substantially higher than the regional average

of 15%. Male unemployment rates are higher, ranging from 24% to 63% compared to 18% regionally; with at least half of those in each area unemployed for more than three years. Female employment rates are somewhat lower, however, a significant proportion of women who work do so in part-time jobs – ranging from 23% to 51% (Table 4.3).

Between one in four (24%) and one in two (48%) residents aged 15 and over were in work. Although not all of the remaining population in this age group were necessarily unemployed - factors such as the numbers of people retired, those continuing on in education or in home duties need to be taken into account – the low level of people actually working in the neighbourhoods indicates an even greater level of joblessness than that captured by the unemployment figures (Table 4.3). Such high rate of joblessness would affect the level of income in the areas; data on the average household expenditure (the only financial data available on a DED basis) ranged from £1231 to £1280 per week compared to a regional average of £1323 (Table 4.5).

Cumulative and inter-related deprivation

In Ireland, the Haase Index of Relative Affluence and Deprivation is used to provide a single measurement of the overall deprivation of an area (Gamma 1998a-d). The index takes into consideration factors such as the social class composition, the level of education, unemployment and long-term employment, the proportion of lone parents and the age dependency rate.¹² Each of the DEDs in the five areas included in this study had the highest possible deprivation score of ten out of ten.

However, while the Index provides an indicator of the cumulative nature of deprivation within the neighbourhoods, the foregoing area analyses suggest these factors are not just concurrent but also inter-related. For example, a connection between education and occupation/class can be seen in a number of areas such as in part of Eastown where the lowest rate of residents with a third-level education also have the highest level of unskilled manual workers; while the Westown DED with the

¹² Each DED is ranked on a scale of 1 to 10. A Rank Factor Score of 1 indicates that an area is amongst the most affluent 10 per cent of areas, whilst a Score of 10 indicates that an area is amongst the most disadvantaged 10 per cent.

least educational disadvantage in terms of early school leaving also has the lowest level of unskilled manual workers. In the inner-city Northtown area, the rate of residents in the unclassified social group was over three times the regional average; there 63% of males are unemployed, 72% of whom have been unemployed for more than three years. This same DED also has the highest level of early school leavers and educational disadvantaged (see Tables 4.2 – 4.4).

Summary of area analysis

The Census data examined for these neighbourhood profiles has a number of limitations, nonetheless some clear trends emerge in terms of identifying socio-economic and demographic factors which encapsulate the shape of a risk environment for the development of localised drug problems. These may be summarised as:

- high levels of unemployment and particularly long-term unemployment;
- a narrow social class composition;
- high population density, and in particular the density of young people aged 15-29 in the neighbourhoods;
- educational disadvantage in terms of the combination of elementary levels of education, early school leaving and minimal levels of 3rd level education;
- a changing local population;
- the cumulative nature of disadvantage in the neighbourhoods; and
- the interrelationship between factors such as class, tenure, education and unemployment.

In the following section, the lived experience of these phenomena by the residents and heroin users will be examined.

Section Two: The lived experience of a risk environment

In my ethnographic study of the areas, many physical similarities between the neighbourhoods were visible. The areas look poor and are poorly serviced and maintained. Rubbish is strewn around the streets and green spaces. Dogs and sometimes horses, roam around nosing through the detritus. Bus shelters and telephone kiosks are often smashed and broken. There are few cars around, most

are old and rusted, some are burnt out. In the flat complexes and suburban housing estates many of the homes are worn and dilapidated, others are derelict or burned out and boarded up, while a select few gleam and shine through the squalor. Public spaces, such as stairwells in the flat-blocks, are poorly maintained, dank and dirty; the areas are poorly lit. Overall the areas look, as Simon aptly described Westtown:

Like a fucking war zone.

The few local shops are like concrete bunkers as if anticipating Armageddon. Inside, high counters or metal screens separate the shop workers from the customers, and most often a huge dog growls restrained by its leash in the corner. The produce is of poor quality but at a high price.

The local public buildings, mainly schools and churches, are surrounded by high walls and spiked railings with their windows covered by mesh cages. Why? It's not as if, according to Peter, these act as a deterrent:

Like they don't keep anybody out because if you're going to rob the school you'll just get bleedin' get over it or else you'd snip them and go through them

he reckons:

It's madness, like them spiky railings just make the place look, just derelict looking, you know, 'cos it looks closed down. Doesn't it? It looks - urban squalor, that's what it looks like.

The areas are physically isolated as if hidden from the rest of the city. In Southtown, one of the estates is curtained off from the rest of the area by a Berlin-type wall. Public transport to and from the suburban areas is limited. Often there is none. At night and weekends the bus service is frequently curtailed because of young people firing stones at vehicles passing through the area; then the nearest bus stop is a good walk away. In any case aside from the few people travelling to work, the residents tend to stay in their own areas; here they feel safer, feel the same as everyone else. In town and the middle-class areas of the city you're noticed as different, you're refused entry to shops and seen as 'common' and ne'er-do-well, so its best to stick with your own people and anyhow there's no money to go anywhere.

There are kids and young people everywhere, on the streets and the green spaces; the young ones running around playing, the older kids hanging out. Facilities for them are minimal. In Westtown there are over two thousand children under the age

of fourteen in the area, yet there is no playground. Sharon, among others, was concerned:

The kids are just all wild around there. They're just like wild animals sure I mean they've nothing to do, do you know what I mean? They're up to everything the kids are, everything.

Residents, from other areas, such as Tom from Southtown, observed a similar phenomenon:

The kids around our way, like the state of them they're going to be nuts when they grow up, they're living, I think they're living to be locked up an' getting chased by the old bill and whatever else. They do be scuttlin' off the police cars and throwing bricks at them and all that. They're only six and seven years old, like that's down in the flats now, not the houses around the flats, like the flats is just a pure no-go area, there's nothing in it, I don't think there's anyone working in the bleedin' place.

Work, or rather lack of it, was the defining aspect of all of the neighbourhoods studied. In some neighbourhoods one out of every two adults had a job, in others one in four. Of those not working, many had been out of work for years, between a half and three-quarters of the men in the neighbourhoods had been out of work for three years or more. Some never had a job, and lived in households where nobody was working and may never have worked. Those who had work were primarily in unskilled, low paid or part-time jobs (see Table 4.3).

Unemployment of this magnitude translated into situations on the ground whereby, as described by Katie:

Nearly every father in this area is unemployed. I think there's about twenty working and then the mothers, some of the mothers might have a little evening job.

The 'little evening jobs' held by many of the women in the area tended to be for contract cleaning (or other work with few fringe benefits) in offices in the city centre and the industrial estates on the city's outskirts. In the early morning and evenings minibuses collected and dispatched this workforce before and after the regular workers finished their shifts. The work was sufficiently low paid not to affect their family's welfare benefits and could mean an extra thirty to fifty pounds a week, but, it was hard work. David recalled:

My mother like she was a widow, she was struggling, she tried very hard. She took all the jobs, cleaning jobs, menial jobs you know and she

worked her fingers to the bone.

With the majority of people in the neighbourhoods dependent on welfare, money is scarce. Angela related the difficulties in making ends meet in such situations:

There are plenty of women around the area that are under great pressure, like financial and social, they are under an awful lot of pressure. I mean if you have a houseful of kids you're given something every Thursday [welfare cheque] that would barely cover the cost of your bills. And you're worrying about the winter for fire, you know for fuel, and your ESB [electricity] and Christmas, and even in the summer it's back to school. I mean kids think it's nothing to pay eighty pound for a pair of runners. If one of my kids wanted eighty pound for a pair of runners, that would leave me with twelve pound to live on for the week ... that's an awful lot of pressure that's on the mothers and the families in the area, like say Jim next door has Nike runners or he has a Reebok tracksuit or she's after getting a fifty pound perm in her hair, I mean you end up then, Jesus, tearing your hair out. And in areas like this, that's when an awful lot of the kids turn to crime. Like 'I'll get the money for me runners, I'll get the money for me tracksuit' and mothers are constantly under that pressure, you know to have money there all the time. And it's impossible when you're living on social welfare. It's really impossible to do it. I mean I've only two and I can barely manage. God help anyone who has, you know, a houseful of kids and especially small ones, you know there's no way, you're scrimping and scraping and I mean no matter what, rent and ESB have to be paid before anything else. I mean an awful lot of people pay their bills before they buy food. It's when the bills are all paid then you go out and do your shopping and you do it the best you can. So everyone is robbing Peter to pay Paul ... and then you have to turn around and tell a child 'no you can't go swimming, I haven't got the money' and 'no, you can't go to the pictures, I haven't got the money'. It's terrible having to tell your child that you haven't got a pound for them to go swimming 'cos that pound will get you milk or get you bread. And I'd rather have bread and milk on the table than have them up in the baths for an hour. And an awful lot of people round here are in the same position and I'd say in most of the housing estates it's the same.

Long-term welfare dependency means having to exist below the official poverty line. It's just not possible. Money must be secured from elsewhere but banks don't serve poor communities. None of the neighbourhoods has a bank, the one in Talltown was closed down years ago as was the bank in Southtown, the latter being replaced by a funeral parlour to meet the local demand as young people died from drug and HIV related illnesses. The closure of these institutions was seen to signify a watershed in the social and economic downturn of both areas. Credit unions, who lend on the basis of your saving record, and money lenders are some of the local alternatives. If

you're lucky the latter aren't charging extortionate interest as Steve described:

Like my ma pays back a hundred pound on the thousand which is the same in any bank. It's ten per cent do you know what I mean. You pay back and you'll pay an extra ten per cent and like there's no such thing when you first start as 'who's working in the house', 'how are you going to pay back', you know what I mean. He knows that he'd get the money back.

The informal economy provides access to otherwise scarce resources (see discussion in Chapter Six). Robbing is an established alternative to remedy financial shortfalls. For Anthony, and many other young people, it was a way of getting money for socialising and clothes. In these instances, it seems not so much that robbing was normalised behaviour, but that robbing facilitated behaviour such as buying clothes, that was normal for young people from more affluent families:

You'd go out robbing from the cars and get a price for whatever and go out and buy yourself clothes and go out drinking if you had the money. You'd try and buy nice clothes you know.

The number of young people (15-29) in the neighbourhoods is high, about 9,000 per square mile in the two inner-city areas of Northtown and Southtown and 5,000 per square mile in the suburban areas (see Table 4.1). Few were still in school or working, Rose recalled how she used to:

Just go round sit in the park or something, or else go round to one of the houses or go up to the fields and just sit round and light up fires.

Similarly, Anthony recounted:

I'd done the first year [in secondary school] but never went in from second year know what I mean. I was always on the hop there was always someone that wouldn't be going to school. Like I was fourteen and I'd know someone who was fifteen and had already left school ... we used to go around town, go buzzing.

There were few facilities for the young people. Local community workers and residents explained how resources were difficult to access, and while capital funding was available to purchase or build clubs there were no funds for ongoing costs such as paying staff and organising projects. Insurance costs were a major problem; in Westown the local community centre had closed its doors because they couldn't afford the insurance premiums. The few clubs that were available were aimed at younger people, as the children grew older there were even less options.

For the most part, it was up to the youngsters to organise their own activities, as Annette recalled:

There was never anything to do around when I think about it, do you know what I mean. We used to hang around under the flats, you know in the sheds, there was sheds and we used to bring radios over and chairs you know off cars and we used to, God when I think about it, we used to sit there you know and have a party and all. That's all, that's what we looked forward to like you know what I mean. That's all we had to look forward to like, there was nothing else. That and going round on horses all day, there was nothing else.

On a given evening there could be a few thousand or so young people doing nothing in a place where there was nothing to do, as Kelly explained:

The culture would be hanging down around the streets a lot, there isn't a lot to do. There wasn't a youth club, there was no facilities, so what we did growing up was we stood around in the street corners talking, you know.

Other young people's behaviour was less innocuous, Frankie and his pals formed a notorious gang in Westown which local adults and the police were unable to control:

We all hung around together, picked up for each other, went off robbing together, bleedin' tribes of us going off robbing for drink money ... we all moved into the houses at the same time, all got to know each other, just made up a place where we all hung around ... nobody would say anything, people used to be afraid to walk through the place, wouldn't come over near us, anybody who'd come over that we didn't know used to get bleedin' slaughtered ... the Garda and all were afraid to come up around the area, anytime they'd come in they used to get lashed out with petrol bombs, bricks, everything.

In Southtown, Tom and his mates had a similar gang; adults who complained about their behaviour were given short shrift:

The auld wans used to like moan about us all at the corner ya know, used to be gangs of us standing at the corners, they didn't understand like what else was there to fucking do, ya know, go in sit in the gaff do nothing, like we used to sit at the corner with a radio, cans and smoke hash an' run amok, the auld wans used ta go mad.

Drinking, smoking hash, robbing cars and 'joy riding' them around the area before setting them on fire formed the ingredients for a night of hanging out, with an additional bonus if the Gardaí became involved in the chase, as Peter and Tom described:

We used to get two litres of cider and like sit down on the main road

watching the bleedin' robbed cars going up and down. [Peter]

Some nights there would be up to thirty of us at that corner, ah it used to be a mad looking sight, there'd be three or four robbed cars at the one time, always loads of fights an all, then all coming up in their robbed cars and dicing each other up and down the roads and crashing into each other, all mad things like that. [Tom]

Jack reckoned that all these activities stemmed from the mass unemployment in the area:

It means that there's a lot more hanging around you know, it's an awful place like for robbed cars and young fellas drinking and that, all the lads that weren't working and that you know do be out at night, there'd be robbed cars and the police would be trying to get them back. Little Chicago they used to call it; that's how bad it was now. Got to the stage the police wouldn't go into it.

On reaching eighteen years of age, the young people could claim social welfare assistance, there were few other options. There were some jobs available but you got them because somebody knew somebody else, no interviews, CVs, or qualifications were necessary. The work was part of the informal economy, money was paid into the hand so there were no records of your work when you went to look for another job, and then you couldn't claim benefits after the work dried up.

Tim's description of his employment history was similar to many others:

I'm on the labour since I was eighteen and I haven't signed off the labour bar being on a sick cert. so I was still being paid. Like if I went into an interview and they said 'what have you done since you left school?' I can't get any records saying I worked here and I worked there, a lot of money went into the hand. I'd have to get a job from someone that knows me who'd give me a bit of work and that's the bit of work I did get, through people I know.

Against this socio-economic backdrop, alcohol, tobacco, hash, acid, ecstasy and benzodiazepines were all part of the young people's drug repertoire. The arrival of heroin onto the local drugs market and into the lives of the residents was seen by Jimmy as being related to the fact that:

You've nothing to do, you're bored silly, you haven't even got your pride, you don't know who you are when you've no work. You've no pride you know what I mean. At least if you're an addict it's something, 'I'm a junkie' do you know what I mean, and that's the truth of it you know. You don't have worries when you're on it you know, you're just, you're

happy. You don't know whether you're happy 'cos you're sitting there watching Coronation Street or 'cos you're stoned out of your head you know. And that's, that's the truth you know. It just takes the worry away.

Drugs in the neighbourhood

In the following chapter, the young people's initiation into heroin will be examined in depth, here I note how heroin arrived into the neighbourhoods and came to dominate the minds and lives of those who lived there. Initially, heroin appeared in the inner-city neighbourhoods, however, over time the heroin scene diffused from the centre to the estates on the periphery. In 1987, when John was sixteen he moved from Westown into Southtown where he began using heroin:

The heroin was all in town at that stage, I'm sure it was out in Westown but it wasn't handy for me you know. ... And yeah by the time I went back to Westown [in 1994] it was just after spreading right through, like a virus, it was just, it was amazing. You could see it like branching out from town, then it just kind of slowly moved up to Westown and it's moving beyond there now you know. It's crazy, it's mad, it's everywhere, it's so easy to get. Nearly every, every person on average over the age of fifteen or sixteen's going to try it at least once. Or most of them are going to end up on it you know around areas like Westown and town and Talltown and so on.

Tom believed that the heroin had diffused into his neighbourhood through groups from the inner-city areas interacting with their peers in the suburbs:

It started off no one was on gear only the ould lads, one or two of the ould lads. We didn't hear much about it, we didn't even know what heroin bleedin was. Then fellas from Southtown started going out with two young ones from the area, and they got on it, the two young ones were first on it, then from the young ones everyone started getting in on it, everyone's strung out over there, everybody's just in bits.

In that same year, 1994, Peter and his mates tried heroin for the first time:

We were all just starting to get into robbing shops and whatever and the gear [heroin] started coming out here. There was only one person up here selling heroin at the time and we hadn't got a clue what it was. Like we'd heard about it back in the eighties but I thought 'gear, everybody bangs it up' and didn't know you could smoke it or anything like that.

By 1996, when the field work for this study was conducted, the sale and use of heroin was clearly visible in these neighbourhoods, Steve's description of the scene was that:

This place is swarming with drugs. Young fellas are walking round like skeletons and zombies ... There's forty houses on my road and there's fifteen junkies on my road. That's only on one road and there's what, three hundred roads you know what I mean. There's about a thousand probably on it.

The impact this has on the neighbourhood is, as Rory described:

There's so much drugs floating about there's so much - it's a way of life, like because nearly everyone around here is on drugs, that it's just a routine, and like life revolves around drugs and it's very hard to go a different way.

The everyday reality, for those living in these areas, is that nearly everyone around you is 'on drugs', and everywhere you go you are confronted with people dealing and using, Ellen found:

All of them are into drugs. It's living in this area ... like you can't walk out on the street without someone bumping into you saying 'gear?' do you know what I mean.

Katie perceived that:

People's minds were just gone over the drugs, too much of it you know.

she related how:

I'd just rather sit in and go to bed at nine o'clock and all rather than sit and listen to another story about drugs 'cos it never stops. That's all you get, it's very stressful, 'cos you're just sick of it. Listening to the one thing, day in, day out and it never leaves you. It's horrible. It's really horrible. In the area there's fights morning, noon and night and it's over the same thing. Drugs. Fighting over 'you owe me' and all that. It's madness.

The concentration of heroin use in the neighbourhoods brings additional problems, such as increased levels of theft and violence, which will be examined in Chapter Six. However, residents also have to contend with drug-related detritus such as syringes, blackened pieces of tin foil, and beer cans (for cooking up the heroin) lying about. For parents with young children there are additional fears for their safety and the influence of growing up in such an area, as Katie related:

It's an everyday thing even to the smaller kids. Like me nephew, even my baby, he's only four, like I was saying to the kids, 'you can go out and play but don't pick up anything'. Ah they're little kids, it's their little hearts you know. They don't know whether they're coming or going and like you have to say it. Like I'm saying it to me baby everyday 'don't pick up anything' and I've even showed him a needle and he cried you know

and he said 'but the doctor has them'. I said 'the doctor's needles is nice needles, they make you better' I said, 'these don't and you don't pick them up or anything' and he seen one there in the Avenue a couple of weeks ago, him and me nephew, and he came in and he said 'Mammy there's a drugs needle out there'. So the neighbour across the road, she phoned the police and they said 'put a pair of gloves on you and pick it up'. I wasn't going to pick it up and I don't think anybody else did so a man across the road just got a sweeping brush. He had to sweep it down the shore 'cos nobody would pick it up. So I was glad I taught him in that way because being curious at his age he would have probably would have picked it up. You know, it's after happening so many kids around the place.

And as Joseph described:

Children - that's their little world they're living in - all around them is drugs, like it's an everyday thing even to the smaller kids.

However, the ultimate price paid by the residents was the level of premature death among the young people from the area. During the fieldwork there were three drug-related deaths in one area in one week, and a number more during the months of the study. Of Tim's peer group:

An awful lot of them are dead, an awful lot of them died from overdoses, one or two died in robbed cars, crashed cars, the virus [HIV] as well killed a few of them ... so there's an awful lot of them dead, actually I went to a mass a while ago and when the names were read out you know of all the people ... like there's only a few of us left now, there's not that many of us left that hung around in them gangs.

The impact of this human tragedy on the neighbourhood was explained by Angela:

We've lost more young people through overdoses, the virus, accidents, all drug-related. Like you go out to the graveyard and you walk along the graves and take note of all the ages. They're all teenagers. The majority of that graveyard over there is teenagers. And the same out in X. If you go back looking to the nineties on an awful lot of the headstones, they're all young teenagers and early twenties, mid-twenties and it's all drug-related. The best part of them are all drug-related.

In the absence of an adequate response from statutory bodies to the crisis in the heroin neighbourhoods, many residents got involved in local campaigns to provide treatment services for the heroin users, and organise street vigils and patrols to halt visible drug dealing in their areas. Community meetings were called to discuss the response often leading to mass marches on dealers' houses and the streets reverberating with the chant of 'pushers out'. However, the overall movement

brought together a diverse range of opinions as to how the crisis should best be tackled, from those advocating a community development response, to those calling for direct action to remove suspected drug dealers from their areas. Many in the community found themselves alternating between the two responses. On the one hand concerned about sons and daughters using heroin, they lobbied for treatment services; on the other hand, frustrated with the impact of the street markets and the extent of anti-social behaviour in the areas, they joined the marches to confront the dealers at their homes.

Over time the movement's lobbying did influence a statutory response in terms of an expansion in treatment services, although there is little doubt that this policy response was also influenced by concerns about the movement's connections with Sinn Féin and the IRA, and was also aimed at diffusing support for the movement. For a time, local drug markets were displaced by the street patrols but in some ways this was countermanded by increased tension in the neighbourhoods between those involved in opposing strands of the movement; and between the drug users and the more aggressive anti-drug campaigners. Perhaps the contradictory effect the movement had on the neighbourhoods is best illustrated by Toni, who had three sons living with her who were heroin users. Each week she and other members of the local drug awareness group would join with the march on the dealer's house only to find, one week, that it was her own house she was marching on.

Conclusion

This chapter began with an in-depth social analysis of the five neighbourhoods which were home to the heroin users who participated in this study. This analysis was based on quantitative data from the population census which was then enriched and qualified by the narratives of the residents and the heroin users and my own ethnographic observations of the neighbourhoods.

Despite the limitations noted regarding the utility of the census data, such as the data potentially under-representing 'the huddles of poverty' within the neighbourhood, as cautioned by Pearson *et al.* (1987). Nonetheless, by comparing and contrasting data from the neighbourhoods, the distinguishing characteristics which they had in common, and which were different to other neighbourhoods, were

identified. Overall the findings were similar to those identified in the deprived working-class communities which had experienced heroin epidemics in the 1980s (for example Haw, 1985; Peck and Plant, 1986; Burr, 1987; Pearson *et al.*, 1987; Parker *et al.*, 1988; Giggs *et al.*, 1989; Mirza *et al.*, 1990). However, by using a comparative approach and by noting variables that were similarly disproportionately high or low in each neighbourhood, and different from the norm (as signified by the average figures for the region), the extent to which a critical mass of residents experienced these phenomenon was illustrated.

A number of defining characteristics of the neighbourhoods were observable. First and foremost was the extent of joblessness, and in particular long-term joblessness in the neighbourhoods. Each neighbourhood also had a narrow social class composition which indicated the ghettoised nature of these areas in terms of the minute level of residents from higher social classes and the high proportions of people in the unclassified social group (those who had never been in paid employment or who lived in households where the head of the household had never been in paid employment). In addition, there were high levels of educational disadvantage and a particularly high density of young people living within the area along with high levels of instability and change in its population. Not only were concurrent and cumulative levels of disadvantage noted but also how they seemed to mutually reinforce each other, as indicated by the inter-connectedness of the data on class, tenure, education, unemployment and poverty.

Data from the qualitative interviews with the residents and the heroin users and ethnographic data from the neighbourhoods helped explore the lived experience of this disadvantage. Overall, conditions in the neighbourhood were seen to facilitate the arrival of heroin onto the local scene and its diffusion from one socially excluded working-class neighbourhood to another with consequent knock-on effects on the neighbourhoods and their residents.

In the following chapter the development of the heroin users' careers in the context of these risk environments will be examined.

Chapter Five

The Heroin Users

Introduction

This chapter profiles the sixty-one heroin users who were interviewed for this research study. A description of their background and drug history is followed by an analysis of their accounts of how they became heroin users; how this use developed into problematic use; and the meaning of heroin in their lives.

The names of the heroin users have been changed to protect their anonymity.

Section One: Profile of the heroin users

The aim of this profile is to develop a picture of this group of heroin users and identify similarities and differences both between them and the general life-patterns identified in the neighbourhoods where they lived, as described in the preceding chapter. The profile of these heroin users was constructed from a selection of key quantifiable data identified in the transcripts of the in-depth interviews; these include socio-demographic data such as age, gender, neighbourhood, age left school etc. as well as data on their drug-using careers (such as main drug of use, age first used, duration of use, mode of administration etc.). A database of these key variables was set up using SPSS software and the relevant data entered. The following analysis is based on the frequency counts and cross-tabulations of the selected variables (see Tables in Appendix 5).

Note, this profile has been constructed to provide an overall picture of the cohort of heroin users that were interviewed for this study. It does not purport to be representative of the heroin using population.

Gender and age

Sixty-one heroin users were interviewed for this study; thirty-four men and twenty-seven women (Table 5.1). The interviewees ranged from 15 to 43 years of age, however, almost all (84%) were less than 30 years of age. The average (mean) age

of the participants was 24 years but most (mode) were 19 years of age (Table 5.2 & 5.3).

Area of residence

The sixty-one heroin users interviewed came from the five working-class neighbourhoods of the city which had been identified as areas experiencing both a high level of socio-economic disadvantage and high rates of heroin use; the same areas where I conducted the ethnographic part of this study as described in the preceding chapter.

A roughly similar number of male and female respondents were recruited from each neighbourhood; 11 in Eastown and Southtown, 12 in Talldown, 13 in Westown and 14 in Northtown (Table 5.4).

Age left school

The youngest age reported for leaving school was 11 years and the oldest 17 years. Both the mean and modal school leaving age were 15 (Table 5.5). Three-quarters (75%) of the interviewees who reported the age they left school were early school leavers i.e. they had left school at or before the age of fifteen (Table 5.6). None had a third level education. While high rates of early school leaving had been identified among the residents in their home neighbourhoods, the rate among this group of heroin users surpasses these by far.

Drug using behaviour

All of the interviewees described themselves as heroin users, indeed they had been recruited as respondents on this basis. However, while almost three-quarters (72%) identified heroin as their main drug, over a quarter (28%) were polydrug users regularly using a wide range of drugs in addition to heroin, mainly benzodiazepines but also methadone, cannabis, ecstasy and alcohol (Table 5.7).

Almost three-quarters of the heroin users (72%) currently administered their drug by injection (Table 5.8). However, a far higher proportion (87%) reported ever injecting a drug (Table 5.9) indicating transitions from one mode of use to another. Roughly

similar proportions of men and women reported current and lifetime IV drug use.

A substantial difference was noted between the mode of first use of heroin and the main mode of current use. The majority of the heroin users (68%) had started using the drug by smoking i.e. 'chasing the dragon', while a fifth started by injecting (Table 5.10). However, this changed over time and almost three-quarters (71%) of the heroin smokers later became injectors (Table 5.11).

Duration of use

Thirteen years was the youngest age at which an interviewee began using heroin and thirty-three the oldest; the modal age was 16 (Table 5.12). Two-thirds of the heroin users (66%) began using the drug at or under 18 years of age (Table 5.13).

While a quarter of the heroin users began their drug career before or at the same age they left school; most notably, three-quarters (75%) began using heroin after they had left school (Table 5.14).

The heroin users interviewed had relatively short drug careers but these should be interpreted in the context of their young age. Their length of use ranged from one to 15 years, however the modal duration of use was two years (Table 5.15).

Almost a fifth of the research participants (19%) had begun their heroin career during the 1980s heroin epidemic in Dublin. Overall though, the vast majority of the participants (81%) began using heroin during the second epidemic which was seen to begin in the 1990s and, in retrospect, be at its peak at the time of the fieldwork.

Family

Almost half of the heroin users (47%) had children; although a higher proportion (58%) of women were parents compared to men (38%). Family size ranged from one to five children; the modal number of children was one (Table 5.16).

There were notable gender differences in the heroin user's personal relationships. Just over two-thirds of the heroin users (69%) had a partner; but more females

(80%) had partners than males (63%). Of those with a partner, nearly three-quarters (74%) had a heroin using partner. However, the proportion of women with a drug-using partner was far higher (90%) than that of men (57%) (Table 5.17).

In addition, just over two-thirds (67%) of the heroin users had a family member, either parent or sibling, with a drug or alcohol problem (Table 5.18).

Drug treatment and current drug use status

Almost all (97%) of the interviewees had received drug treatment¹³ at some stage during their heroin career (Table 5.19). A similarly high proportion, over three-quarters of the sample (79%), were in treatment at the time of the interview. Almost all (93%) of the female heroin users were in treatment compared to less than half (48%) of the men. However, this may reflect the recruitment sites chosen for this study rather than any significant gender difference in treatment rates (Table 5.20).

The highest proportion of those in treatment (42%) had been so for less than three months, while overall two-thirds (66%) had been in treatment for less than six months (Table 5.21). This reflects the prevailing context in which the fieldwork was conducted when there was a dramatic expansion of drug treatment places made available in Dublin.¹⁴ Interestingly, despite the high proportion of interviewees in treatment, almost half of the sample reported current heroin use - defined here as using on more than one day in the last seven days (Table 5.22).

Summary of profile

This profile of the heroin users demonstrates a number of similarities among the group:

- high levels of educational disadvantage;
- early age of first use (while still officially 'a child');

¹³ 'In treatment' is given a broad definition here to cover the main treatment modalities available in Dublin such as drug free therapeutic treatment, methadone treatment and social reintegration courses.

¹⁴ Between 1990 and 1998 the number of Eastern Health Board (i.e. mostly Dublin city) residents receiving drug treatment increased substantially from approximately 2,000 in 1990 to 4,000 in 1996 and 5,000 in 1998 (see O'Brien and Moran, 1998; Moran, O'Brien, Dillon and Farrell, 2001).

- drug use which intensified after leaving school;
- risky drug-using behaviour such as poly drug use and high levels of injecting drug use among both men and women (albeit most starting their drug-using career as heroin chasers);
- high levels of drug and alcohol use within the family and among the partners of the heroin users, especially among the women; and
- a high level of ongoing heroin use while receiving treatment.

The issues raised here will be returned to and explored in greater depth as they reoccur in the forthcoming narratives and discussions.

Section Two: Developing a heroin career

Initial use of heroin

All of the heroin users recalled the first time they used heroin, with the younger heroin users, who had started using in the mid-1990s, having a particularly vivid recollection of this experience. Most recounted how they had extensive experience of using cannabis, alcohol and ecstasy beforehand. However, some of the research participants, such as Maria who “never drank or smoked”, started their drug career with heroin. Mark not only started with this drug but also mainlined the drug from the onset, even though chasing was, at that time, the common mode of administration for first time users:

I'm on heroin since I was in school. I was only fourteen and a half years of age, and I didn't smoke hash, I didn't, there wasn't any other drug, just straight into heroin and I didn't skin pop it, I mainlined it straight away.

For the majority of the participants who began their heroin use in the mid-1990s, two main categories could be identified as to how they were first introduced to heroin. For those coming from the suburban estates of Eastown and Westown, initial contact with heroin was mainly through the thriving rave scene in Dublin during the early 1990s, as the drug was not available locally at that time. Whereas for those from Northtown, Southtown and from Talltown, where heroin use had been part of the neighbourhood since the early 1980s, the introduction came mainly through family members and neighbours who were existing users.

The rave scene

Many of the heroin users recalled with fond memories the heady days of the rave scene, which in the early 90s was primarily a working-class youth phenomenon, when thousands from all over the city would gather at the Asylum and Olympic venues at the weekend. There was much anecdotal evidence from key informants that heroin became available at the venues as a calculated marketing ploy with dealers offering 'party packs' containing a supply of Ecstasy along with heroin to smoke as a 'come down' afterwards. None of the heroin users interviewed mentioned these 'party packs' and many dismissed them as fabrications, although they noted that heroin had begun to appear on the rave scene at this time. In contrast, their perception was that as the rave scene was targeted more and more by the police and venues were closed down, that heroin filled the vacuum left behind. As David recalled:

When they closed the Asylum, the place I went to every Friday and Saturday night, where say two thousand young people went, when that closed down there was two thousand extra young people wandering around the streets with nothing to do. So like even when that was open, towards the end of it, you could see gear was creeping in on the scene and then when that closed there was a drought ... a lot of E got found about three weeks after that around Dublin so there was no E and here comes in gear [heroin] at twenty pound a bag whereas it was forty and then there's no rave open to go to, so what can you do. You can either do nothing or you can buy gear and go home and smoke it. That's like the way I look at it, it was like a chain of events that led one to the other.

This population of rave goers provided a ready market of people for whom drug taking was already an established part of their lives. In the raves and hanging out at post rave parties, heroin slipped easily into their lifestyles. Jessie recalled going back to a mate's house and being asked if she wanted to do a few lines - "that's how I got into the gear, it was just passed around".

Tony's description of how he and his mates drug use expanded over time, had many similarities with the accounts of other heroin users:

I started off smoking hash, all me mates were smoking hash. We hung around with a fella he was selling the hash and we were smoking and after a while we were given the hash to sell. And then the rave scene started coming onto the scene you know, so then we were going to that for a while and then we started taking acid. We were offered acid in the

rave you know the Olympic. Then we started taking that and then a few months later the Es, we were offered Es and we got well on, there was a great buzz off them, well better, you don't be freaked or anything it's just a happy buzz you know. So we done that, we were doing that for a few months as well then, we were selling the Es and then after a few months a fella I knew had heroin one night so we tried that then.

Families, peers and neighbourhood

For those from the inner-city areas, the main point of contact with the drug was through their peer groups and families in their own neighbourhoods. In some areas heroin use had been part of the local culture since the 1980s, not only had it become embedded in particular areas of the inner city but within the extended family network - parents, cousins, uncles, aunts, brothers and sisters - which was the typical family structure in these area. As Patrick described of his block of flats in Northtown:

You'd have four or five families that's all related, about fifty of them altogether, all cousins, you know, and brothers and sisters living in the flats.

Annette, belonged to such an extended family, and related that:

It was hard growing up there you know, like there was a lot of drugs involved around there do you know. Me family was on drugs and me sister was on stuff like, so I knew what drugs were from the start growing up.

Overall, more than two-thirds of the heroin users had a family member with a drug or alcohol problem. As a result, there were many accounts of heroin use spreading through families, as was the case with Sarah's partner:

He started, his brother started then after, then his younger sister started, and then his younger sister's fella started you know that sort of way like.

and Anthony's family:

Me Ma ended up with four of us addicts. And you know most of the people that were there in the flats, they all ended up with at least one addict in the family.

The concentration of heroin use within a number of the families mirrored the concentration of use in the neighbourhood. However, it was not just through family contacts that heroin use spread, peer networks also facilitated the exchange and

consumption, as Samantha related:

Like where I grew up I grew up about, everybody sort of knows everybody do you know what I mean. And everybody you know the one age that grew up together, they all do the same thing. If one done it, everybody done it you know and that was - it was just the way it is you know out there, one young one smoking hash and everybody done it you know.

As illustrated in the profile of the heroin users, nearly all of the female heroin users had heroin using partners. Indeed, many of the women described how they started on heroin after their 'fella' introduced them to it, relating similar experiences to Sarah's:

All the blokes started on the drugs, and we were all the girls that hung around with them so it was kinda a gang, you know that sort of a way, yeah, well they were all doing it so we wanted to do it, do you know what I mean, so that's how it started, one ended up taking it, the other, then the other, then the other, and then we all ended up taking it, it started out like that.

Nonetheless, despite the accounts in the previous chapter of the apparent effortless by which heroin appeared and swept through the neighbourhoods, the heroin users' accounts also demonstrated that is possible to live with heroin - either in the neighbourhood, family, partner, peer group - and not try it, or postpone taking it for some time:

Well I knew a lot of people on drugs, on heroin, and I knew where to get them and all 'cos I was hanging around with them and all for a long time before I actually ever touched them.

However, although we know it is not likely that every one in these neighbourhoods tries heroin, there appears to be a law of increasing probability that the longer young people remain in situations of recurring offers, the more likely it becomes that they would eventually try it.

The first experience

Running through the heroin users' narratives, a pattern could be identified of the contextual factors which facilitated their first use of heroin - access to the drug; being in the company of others wishing to use and with someone who knew how to administer the drug; and, having a place to use the drug. Simon's account of when he first used heroin encapsulates these factors:

Her name was Toni, I started to get to know her and her friend Jenny and like well she'd tried heroin a couple of year ago and she said to one of me friends, Mike, whose mother died from AIDS, she said to 'Mike, did you ever try heroin' and he says, 'me cousin sells it in Southtown' and she says, 'would you be able to go down and get it?' And he turns round and he says 'no, he'd batter me if he found out that I was trying to buy that'. And she says 'I'll give you the money and all'. 'I tell you what', he says, 'I'll walk you down and I'll show you and like, you can go over yourself, score off him'. So she scored, and she says 'do you want to come and have a smoke' you know. So we, we were all you know, 'what is this' you know. And we says 'yeah, we'll go, we'll go yeah' so we went down, we were down the canal at the back of this big house, down like you know, kind of an abandoned area with a little table and we had our little seats and all like a little bed, like it's all gone now, but we had our own little chairs and all, our own little table like where we used to smoke our hash like you know. And she - we brought her there with the heroin - she used to smoke it, like she smoked it and she passed it to me and I didn't know what to do and I says 'will you do it for me'. And she says, 'well stay behind the black blob and suck until you can't anymore, and just leave room for the smoke' and she showed me herself doing it like this, so I started doing it and I started sucking it in and through the tooter, the piece of tin foil you hold in your mouth you know, blowing it back and like it was just, I kept on going, kept on going like thought there was nothing like it. And then the rest of the boys thought it was great you know, thought it was great and I was only sixteen at the time you know. I didn't feel sick or anything, no, like four lines or something I'd done, and I felt grand.

Simon's account was unusual in one respect, in that he didn't feel ill on this first attempt, as most people reported. In fact a curious mixture of pain and pleasure appeared to be the norm with the pain a bizarre part of the attraction, as Tina described:

The girl I used to pal with, I palled with her since I moved up here and like the two of us started one night just after an E you know and like we were vomiting our rings around the place and like we said, no, no, no, we wouldn't be into it, it's horrible, it's horrible, but the feeling you got off it you know was nice.

Samantha's experience was similar:

The very first time I took it, after I had taken it I got a lovely buzz off it. I also got very sick off it. I couldn't figure out for the life of me what it was that people saw in it you know 'this is shite I'm not doing it again' it made me sick you know, 'cos it does, it just makes you violently sick. I was sick on it for a good while you know, throwing up ... you can see them all sitting around big plastic bags. I think it has that effect on most people in the beginning you know, although you get a lovely buzz off it and all you know, the stuff that goes along with it is shite for a while. Just even the smell of it or just hitting off the back of your throat or

anything, just makes you, you know it's just got that nasty, vile smell and taste of it.

But for others, such as Annie, the pleasure outweighed any pain:

I thought I was going to die if I did this but I didn't, I got a lovely stone out of it. It's lovely relaxation like but I didn't actually get sick the first time funny enough, I didn't get sick. I had a lovely sleep and I think that's what it was, sleep, and you know a lovely feeling and all like, you've no pain inside you. So then, you want to walk for miles like, but yet you know, if you sat down you'd like [yawns], you know you couldn't move, you'd be so wrecked. But yet once you get up and walked, you could walk for miles and it's a lovely feeling, feels as if you walked along in little fluffy clouds, you know what I mean. It's mad it is.

For her and many others this intense experience of pleasure led to them trying and trying the drug again, for as Bill described:

Once I'd tried heroin the first time, I knew that this was it, this was the drug that I wanted, I remember the place the time, the day even and I just knew that this was it. I had found my little corner of the world.

Access

In addition to the pleasure-pull of the drug, a key to the individual's and/or group's development of a heroin habit appeared to be the nature and frequency of subsequent offers and easy access to the drug. Consequently, those living in areas where heroin was a local commodity to the extent that, as Anthony described, "you wouldn't have to go look for it" found themselves in recurring offer situations. Such ease of access to the drug - all Tricia had to do to score was "walk down the road and whistle" - appears to be a crucial contributory factor to consistent use, as Christine described of living in the flats in Southtown:

All you'd hear was 'do you want anything?', 'do you want anything?' 'are you looking?', 'are you looking?', do you know what I mean so they'd be all around you, or else all you'd have to do was walk in a flat and say 'have you got anything' and they'd say 'no but so-and-so has it there' and 'go up to the stairs' or - like you wouldn't have to actually look for it, you'd be getting told.

Sarah's experience in Talldown was similar:

It was like, everyone in our block was like a junkie, that sort of way, so you'd be kind of running up and down the stairs like and you'd be running up to this person, looking for that person or they'd be running to you, you know. Like in my block, they're selling it on the landing that I live in, over me, under me, and downstairs on the block. And then

they're selling it on the next block to me and the block after me so either way, there's heroin all over the place

Another factor facilitating the continued use of heroin was ongoing access to a place to use the drug, this was especially the case for those smoking heroin who needed time to administer the drug and a wind-free area to smoke it. Empty flats, 'free houses', or stairwells of flats, were appropriated as drug-using locations. Rose and her mates accessed a 'free gaff' in exchange for drugs, she described this as:

A house where like there was no parents there and you know it was kind of a crack house [although heroin was the drug being used] or whatever, you know one of them houses where you just go in and everyone is smoking.

Status

Many of the heroin users were attracted by the junkie lifestyle and the status they perceived as accompanying the use of the drug. Interestingly, it was not just the men who were attracted to this, as Sinead recounted:

I always wanted to be this mad junkie and look at me I'm great and like I'm not going to be like them eejits in school doing their homework. I'm going to be out on the street drinking and fighting and getting arrested. I used to think when I got arrested that everyone would be looking at me saying 'she's great'.

Others like Christine, were also fascinated with the scene and the style and status that she associated with heroin use:

My friend's brother was on it. He was on heroin nearly all his life do you know what I mean but he was this type of one that had a car and his pager and the money and the clothes, and the fellas used to always stand on the corner [one of the dealing areas in Southtown] like I used to be, ah I used to be fascinated with them and always wanted to be over there wondering what was going on. I used to think they were real cool and you know all that. I just wanted it, do you know what I mean ... I used to see all the junkies walking up and down all the time and I used to think they were great. I did. I really thought it was great. Yeah and even the ones that'd be sitting on the wall and they'd be falling over asleep and I'd be saying 'God I'd love to be like that', to see what it's like do you know what I mean.

Indicators of problem use

Concern about becoming addicted to the drug did not feature in the initial stages of heroin use, despite those growing up in the inner-city neighbourhoods having viewed

at first hand an earlier generation of users who had become addicted. Most believed that it would never happen to them, that they were only going to use it once or twice a week, or that by smoking rather than injecting the drug, they would never get addicted, Tony reckoned people thought:

No, it'll never happen them, they'll never get strung out you know what I mean. Everyone says that. They're not going to get strung out like. Nobody goes on gear planning to get strung out, you know what I mean.

Of this sample of heroin users, however, many found their level of use escalating with time and, as a result, moving on to buy larger quantities, as Annie recalled:

We started off on little amounts, and then it got to a stage you know where in the morning you have to have gear first thing in the morning or else you just can't get up out of bed. Then in the afternoon you've gear, tea time you've gear and then before you go to bed you've gear - like so we started getting half grams then.

Coping with the sickness

One of the key turning points in the heroin users' drug-taking career was seen to be prompted by the onset of 'the sickness' - the term they used to describe the painful withdrawal symptoms experienced when the effects of the drug began to wear off and the craving for more grew. Among the symptoms listed in the Opiate Withdrawal Scale (OWS) are nausea, vomiting and diarrhoea; generalised aches and pains; abdominal cramps; and feeling hot and cold (Gossop 1996). Symptoms which were vividly described in the heroin users' narratives of 'the sickness':

Getting the sickness is not in your head, it's the dry retch, the cold sweats and then the warm sweats, and then the pains and the headaches. And like that's a sign to go out and have a turn on, that's a sign to me. [Maria]

If you haven't got your gear, everything, all, your whole system breaks down. You're puking, you're just going to the toilet, like everything breaks down. [Pat]

You wouldn't be able to move, you're just so weak there you know what I mean? You're shivering, you're shaking, you're sweating and you just can't do anything. [Caroline]

Once the 'sickness' became a recurrence, the rationale for taking heroin became less about getting a 'buzz' and more about stopping 'the sickness' and feeling normal again. As Sadie and Anthony recounted:

At the beginning it was nice, I would get stoned on it, on half a bag, but then after that I only take it for the pain, now it's just to kill the pain, to be able to get up. [Sadie]

Sometimes you don't even get stoned, you know like, it just straightens you out heroin does, you get stoned on it for the first few days and then after that, you know, It's just keeping you together. [Anthony]

Among the users who smoked heroin, an initial reaction to the 'sickness' was to change their mode of administration to injecting the drug as, leastwise initially, a better buzz was produced from a smaller quantity. As Sharon recounted:

I was dying sick, right? There was other times I was dying sick and people got me a turn on [IV] and I wouldn't take it ... but this day I was dying sick and I was after going over and he said he'd get a ten bag and he says 'I'll give you half but a ten bag is not going to get us very far if we split it in two, you'd be better having a skin pop out of it'. And I says 'will it hurt me?' - 'No', he says, 'it'll only sting you for a few minutes'. So we went and got it. And, it got me together.

However, over time, coping with the sickness and the frustration of trying to duplicate the initial buzz that taking the drug had produced, led many of the users to adopt strategies to control or cease their heroin use, as will be discussed further in Chapter Nine.

The heroin network

All the heroin users' narratives describe how their initial use of the drug was a group activity. For some, their peers' lack of interest in using heroin curtailed their own desire to experiment further. For example, although Tony lived in an estate where access to heroin wasn't a problem, heroin wasn't part of his group's scene, so after his initial experimentation he stopped:

I got it once, I was only fifteen or sixteen at that time. And I tried it once and then like no-one around me, none of me mates or anything like, they never done it, no one that I was with like, no-one that I knew was on it so I wouldn't just go off and get it on my own at that time, like I just tried it once you know what I mean and like I got the buzz for it and all lovely do you know what I mean. And then later when it was really around and all me mates started on it, that's when I was saying, ah yeah, bleeding lovely yeah, I didn't think twice.

In addition to the solidarity of the shared experience, there were practical reasons as to why heroin use is initially a group activity. For example, the skill involved in

learning how to use heroin, both smoking and injecting, required practice and assistance to learn how to administer the drug properly. However, as the users' started taking increasing amounts of the drug, the communal, sociable aspects of taking the drug are lost - it becomes everyone for themselves. As Tricia described:

The first time I took it there was five of us in the bag and then it was enough for you know a few days, and then 'cos there was so many of us like if I couldn't get it someone else would so we'd always have it. Then it got to the stage where two of us were getting it and then another two, then that was no good, I was getting it on me own and getting two and three bags.

The break up of the heroin networks, as more problematic levels of use developed among its members, was a common story, as John explained:

I began moving around from different mates then, you know we kind of split up 'cos heroin does that to you.

It appears from the interviews that the transition from the shared experience of heroin use to focusing on their own individual needs signified a turning point in their heroin careers – from experimental to dependent use, as Joni related it became:

No bleeding fun anymore, like you're going out you're robbing you're getting charged, it's day in, day out, it's all just to get yourself well just so's you'll be alright.

The meaning of heroin use

To date, the discussion on the factors facilitating the initial experimentation with heroin and the development of problem levels of use has dealt with mainly functional aspects. However, the heroin users' analysis of why they used heroin and developed a problem with it, seen to be more about the 'meaning' they attached to this activity. The meanings ascribed by them can be grouped into two main categories: the search for a 'buzz' out of boredom and lack of alternatives in the neighbourhoods; and the soothing effect of the drug itself on their often fractious lives.

The relentless grind of boredom and nothing to do, was common to all their heroin users' narratives, for example:

There's fuck all to do around here, if you want to do anything you have to do drugs, that's why nearly everybody's on the thing, there's fuck all to do. It just started from hash you know what I mean, hash and drink

and then acid came out, then people started taking acid then going dancing and that's when it came to E, it just kept on going on and on, you know the way to have a good time was be on drugs. [Tom]

People don't know what to do with themselves there's nothing really to do here just hang around ... I think if I'd got a job I'd have had something to keep myself occupied. [Anthony]

It's out of boredom, that's all it is. Like, I had a job and all you'd have to get out of Westown if you want to stay away from gear, even if you had a job you'd get strung out. It's just drugs there, that's all there is. [Terry]

'Cos its around now, loads of it, and because its so cheap [Frank]

There's nothing around here really at all. That's how everyone gets on drugs and all, with boredom you know. Just be too bored you know. That's the way everyone gets messed up on drugs. [Damien]

Nothing to do at all, that's how we started off on drugs like, fed up all day, thought might as well try this. [Mark]

Half the people down there wouldn't be on drugs like if the education had have been better. Like if you had something to do, if you had a job. [Brian]

In this context, heroin and other drugs provided 'the buzz' and the excitement that was missing from their lives. However, for others the impetus seemed to be an escape from the harshness of their existence:

It takes all your worries away. [Jack]

I just wanted to escape from reality and hide from my problems. [Margaret]

It's, I think it's that feeling it gives you. If you're on it for so long it gives you a feeling of security like you actually feel secure when you're on it, mentally, and actually physically. Like you feel grand when you get it into you. [Pat]

Just wanted to get out of the hell, just to be somebody else ... anything that would put me in a coma. [John]

Conclusion

This chapter began with a profile of the heroin users interviewed for this study. The profile demonstrates a number of similarities among the group in respect to high levels of educational disadvantage; early age of first use; drug use which intensified after leaving school; risky drug-using behaviour such as poly drug use and high levels of injecting drug use; high levels of drug and alcohol use within the family and among the partners of the heroin users, especially among the women; and a high level of ongoing heroin use while receiving treatment.

The chapter concludes with the heroin users' description of how their drug careers developed. Four key elements, most very practical, were identified as necessary for heroin to be used for the first time. First, the potential user had to have access to the drug, either by deliberately seeking out the drug, or being in a 'drug offer' situation. Secondly, they needed a 'guide' i.e. someone who knew how to administer the drug. Thirdly, the (potential) user and his/her/peers had to be psychologically disposed to trying the drug. Fourthly, they had to have a place to use the drug.

However, for those continuing to use and developing a heroin career, the need for some of the above elements, such as a guide, was no longer necessary. However, access was seen to remain crucial as was space both in its physical meaning and in terms of lifestyle capacity. They also still needed to be psychologically disposed towards the drug in terms of the meaning heroin held for them.

There was little to indicate, in the heroin users accounts of their drug career, that they had progressed from one drug to another. Indeed, the data suggests that factors such as other drug use; hanging around because of exclusion from the employment market and/or the education system; seeking a buzz or status as an alternative to the boredom of everyday life; and, being in recurring 'drug offer' situations, all contributed to the development of a heroin career.

The following chapter will now examine how these heroin careers developed further in the dynamic context of local drugs markets.

Chapter Six

The dynamic of local drugs markets

Introduction

In earlier chapters describing neighbourhood conditions and the development of drug-using careers, the issue of access and the availability of the drug through a local drugs market was noted and seen to be a contributory factor to the development of individual and neighbourhood drug problems. The purpose of this chapter is to explore these issues in greater depth, to examine how and why drugs markets develop and are maintained, and the impact they have on the individuals involved and on the neighbourhood as a whole. In so doing, the social and structural processes ongoing in the neighbourhoods are further unravelled.

Local informal economies

Each of the five neighbourhoods examined in this study had a thriving local drugs market, but they also had a thriving informal economy that preceded the drugs market and, for a time at least, both were seen to operate in synergy.

The activities of the local informal economy largely revolved around the theft and sale of stolen goods through which residents could access goods outside their financial reach (see descriptions in Chapter Four regarding the difficulties encountered in living on welfare payments). As this local economy was beneficial both to those involved in the theft and sale of stolen goods, and the wider population in the neighbourhood who purchased the goods, acquisitive crime was accepted as a local social norm. People in the neighbourhoods rationalised this in a number of different ways, it was an intrinsic part of their way of life as Joseph remarked:

People rob because that's just what they do.

Others considered the informal economy as providing a means of survival given the shortage of money due to unemployment, low wages or welfare dependency; and an absence of more legitimate opportunity structures to access food, clothing and household goods. As David noted:

If they had work, they'd have an income, well they wouldn't need to rob

would they?

In this sense, these activities can be seen to have a clear functional purpose in terms of what Merton (1957) would term accessing material gains through illegitimate opportunity structures. However, robbing also offered a structure and routine to otherwise routineless lives, as Lucy commented:

I'd often be gone from nine in the morning 'til the shops shut at night, shoplifting, like I always did it, even before I was on drugs, so I was used to it, it was like work nine to five!

The operation of the informal economy was also justified by a Robin Hood view on wealth redistribution, and an ethical code whereby it was okay to steal from the rich but not from your own people. As Simon explained:

I was never into snatching women's handbags or anything like that. I despise anyone that does that you know, robbing handbags or burglaries breaking into houses or anything do you know, I never done that now, but like whatever any of us robbed, it was always robbed from shops like the likes of you know, big shops in town, like you know the jeans shops that sell Ralph Lauren's, and all that kind of sports stuff and camera shops and fucking Walkmans and computers - all that kind of stuff you know.

For many young people in the socially excluded neighbourhoods, initial deviant activities such as shoplifting, car-theft and joy riding were done for the excitement and 'the buzz' when there was nothing else to do. However, as they grew older robbing for 'the buzz' transformed into seeking funds to socialise and engage in everyday youth activities. For them acquisitive crime offered an opportunity to be a consumer of the heavily marketed youth lifestyle to which they had no conventional access, as Frankie and Daniel related, brands and image were important to them:

I'd think of nothing only just going out to rob, having money, buy clothes. Ma would buy clothes for us and all but we always wanted the best of clothes, £100 runners, Nike and all, had to be up with the fashion. [Frankie]

We used to come out with about six, seven hundred pounds worth of clothes a day and you know, we'd have the best of clothes on us. And when we were selling the clothes, the shirts and jeans, Levi jeans and Levi shirts to blokes for twenty pound a pair each, we had about a hundred and fifty, two hundred pound in our pockets a day driving round. [Daniel]

However, as the level of their heroin use grew, robbing became more a means to

fund their drug habit than finance their social life and lifestyle. As Francis described:

In the beginning it was for the buzz, then the money, then the drugs came so it then supported me habit.

Financing drug use

The informal economy operating in excluded working-class areas provided an ideal opportunity for heroin users to earn their drug money. The social changes and economic restructuring which took place in Ireland in the 1970s and 1980s, when heroin had first become available, left a more socially and economically segregated society. And, with more people out of work and living on low welfare payments, there was a greater demand for cheap goods - a market niche that the heroin users were easily able to fill.

At the onset of their heroin using career, robbing was an obvious and easy means of financing their drug habit. However, as their tolerance for heroin increased so too did their level of robbing as more and more funds were needed to purchase the drug, as Paul related:

When I started smoking more you'd see the increase in me shoplifting like I wouldn't take little things I'd be taking it in bulk, take the whole rack 'cos you know you have to get twelve or thirteen bags [of heroin] and a few bob for your cigarettes and your taxis.

Initially the local informal economy was seen to benefit from the plethora of stolen goods made available by the heroin users, who were agreeable to taking orders for specific goods, as Ali described:

A: Like, when we used to shoplift we'd go around the doors selling the stuff like ...

Q: And would you get much of a deal when you were going around selling your stuff?

A: No, most of the times like, it depends really on what you were selling like, most of the time, you'd just like whatever you'd say the price was you just charge them half, either half the price or less than half price on whatever it was.

Q: And what sort of stuff used you lift, clothes?

A: Clothes and make-up, toys whatever, clothes mainly, perfumes whatever, it would get so people would ask you to get them this and get them that, whatever.

Over time though, the increased levels of theft from the heroin users led to a more plentiful supply of stolen goods, and with the local market saturated few of the

heroin users could get the usual going-rate for stolen goods of half the shop price, as Charlie and Tricia related:

Well I'll tell you for instance, I got a video and I gave it away for fifteen pounds, brand new in the box, because I couldn't sell it and I needed me Phy [methadone] that night. Fifteen pound. The guy knows he's getting it for little or nothing. He'll say, 'Ah look I can't afford it, I've only this' and 'I'll see' and bargain you down to bits you know. Your man's walking off, Oh Jesus what'll I do, what'll I do. I have to, and he knows you're going to have to sell it to him. [Charlie]

You never get a good price for things, not anymore. You used to, but then other people got into going selling for next to nothing. Then you'd have to start selling your stuff for next to nothing. [Tricia]

In the absence of good prices for the goods they stole, and with increasingly high drug-use costs, selling drugs offered a more lucrative means of covering their drug costs, as Frank remarked:

I mean you have to do some crazy amount of robbing to feed a habit. I mean you just have to go all day, you just fucking rob anything that's not glued down and get back, get your gear into you. Then you're going back out for more. Then you're better off selling it, you know.

Dealing

Many of the stories recounted by key informants and related in media stories of 'drug pushers' preying on innocent victims found little resonance in the heroin users narratives. Instead a complex picture of a drugs market with many levels of overlapping involvement emerged; from the user-dealer selling to his/her peers to pay for their own use, to middle-level dealers who were more profit and status oriented.

Dealing cannabis and ecstasy

A number of the heroin users described how they had been successful at selling drugs, cannabis and ecstasy mainly, when they had been taking those drugs themselves. The money to be made doing so gave, what Frank termed:

Money for playing with, you know. Just you always had money in your pocket. You had a drink, buy clothes with it. Whatever you wanted to do. Basically you always had to have money.

Ecstasy was particularly profitable and easy to sell and afforded some financial freedom, as Tom described:

There's a lot of money to be made on E, a lot of money, I was making serious big money out of it, like I was selling them for fifteen pound, buying them for four, that's eleven pound profit on each one, you're selling up to a hundred at a weekend, just a big profit to be made on them. Like we'd get our money into the rave then our money back to the B&B whatever, then our money for our gig, so we used to sell what, say a 100 E a weekend, and the money from that would be our weekend out, we wouldn't have any money left on Monday but all through the weekend we'd have our money and be able to do what we want.

However, as the respondents began to use heroin even more funds were needed to finance their habit. Some, like David and Tom, resorted to selling 'rip-offs':

I didn't have to rob at that stage 'cos I was selling Disprins. Like I was buying a hundred tablets for a few pound, draw a dove on them and making nine hundred pound a week. [David]

Like if I'd no money on a Saturday or whenever I'd get a box of Anadin and just get a nail file and scrape the sign off it and just break it in half and wrap it in a skin, used to make a fortune that way. [Tom]

Overall though, those who had been involved in selling cannabis and ecstasy found their heroin use brought them into different drug networks where heroin was the main drug in circulation. And as 'scoring' heroin became the main focus of their daily activities there was no time to spend dealing other drugs in a different drug scene.

User-dealers

For the heroin users, the ideal situation was to be able to sell enough heroin to 'feed' their own habit. Dealing at this level usually entailed buying a 'batch' of heroin for £100, which contained sixteen to seventeen 'bags' or 'Qs' - the usual retail unit. The sale price of these Qs varied over time and place, but at the time of the research the going rate was £10 (having fallen from £20). This left the user dealer with six bags for their own use or £60 profit. As Rose described:

A: I ended up selling it and all for a while just to feed me habit like. You'd get sixteen bags and you'd keep six and sell ten, then do it again later. And I used to sell ten in about two hours do you know what I mean. So you were guaranteed twelve bags a day.

Q: And where were you selling it?

A: Mostly they were all knocking at the door for it and then I used to just run around and like, you know, I'd be walking and you just, people

just come from everywhere do you know what I mean, in ten minutes you'd have a batch gone.

Becoming a user-dealer came about, like the use of the drug itself, through drug networks, friends, or neighbours already involved. As Rose described in her account of how she started dealing:

Q: And was it easy enough to get into dealing?

A: Yeah, I was dying sick that's how I got into it. I was dying sick and I was talking to somebody and they asked me - it wasn't for them, it was for someone else - they asked me did I know someone who'd do a bit of selling around Westown 'cos they heard there's not much going round there. And I wouldn't have done it only for I was in bits and I said I'll do it just 'cos I knew I'd get a tester and all you know what I mean. So I said right and I met your man.

Q: And was he from the area here?

A: No, I didn't know him. I knew the person who asked me but I didn't know the fella like that I was doing it for. So we went around in the car and we were to meet him at the shops over there, so he gave it to me and I just sold it then. That's how easy it was.

For most user-dealers, though, the increased access to the drug led to an escalation in their drug use and a consequent dipping into their profits. Few were able to maintain the balance between using and dealing:

When we was selling it, we never made money out of selling drugs, you know like profit, like we'd smoke every bit of it and we wouldn't stop 'til it was gone. And that's when the real tolerance went just sky high, it was mad. [Sharon]

We weren't saving anything, we weren't bleeding doing anything do you know what I mean like. As soon as we'd have a few bob we'd be after going out spending it on clothes or whatever, you know what I mean. We'd have a few bob in our pocket, we'd be well nourished inside with gear. Then things would start to go down. Then we'd sell the clothes to get the money and God we used to even have to go out and buy gear on the street as well as selling it, we were just going through it like nothing. [Joni]

It seemed like a catch 22 situation for most people involved at this level. On the one hand they were attracted to the heroin scene by the buzz, the status, the effect of the drug and the opportunity for making some money, yet the more involved they became in the scene the greater the likelihood that their use developed into dependence and a more chaotic lifestyle ensued. As Frank remarked:

Most people, maybe one out of every ten make money out of it you know. The rest of us end up addicts, strung out and all.

Mid-level dealing

Some of the more entrepreneurial heroin users moved up the drug dealing ladder when they saw the considerable profit that could be made buying in bulk - half grams, grams and ounces. Many of the heroin users became involved at this level, though for varying lengths of time. Frank who operated in Easttown and later moved to Northtown had a specific clientele working in the sex trade who bought copious amounts of heroin and cocaine, even though the latter was a scarce commodity and very expensive at the time. He related how he used to:

... buy a quarter ounce of coke and a quarter ounce of heroin and sell them that day so, you know what I mean like, so you only had to sell half to make your money and then take the rest. We used to spend four hundred pound on heroin and four hundred pound on coke and get eight hundred pound back on each one. Spend four and make eight. Double your money. I was slaughtering it all, yeah. But you always had money in your pocket. Someone always owes you money you know. Like, I had like about ten people that I used to sell to. Like I got to know a bird that was a prostitute and I got her to get me loads of customers that were prostitutes. They come out late at night and every one of them could spend a hundred, two hundred pound each. So with customers like that you don't need many more you know. That was it, late at night, it was always between about one, two three, four in the morning so you didn't need to do much else, just put your phone on twelve o'clock at night. That's it, it's gone by four you know. Pretty sound so.

Others such as Annie, Jessie and Paul who sold independently of each other in Westtown, got involved higher up the dealing scale and were involved in cutting and bagging the drug for sale. As Paul related:

You can buy in weight and then start selling yourself that's what I started doing, buying ounces of it, half ounces for £900, £1000. There was good profit in it, you get your profit out of it then you'd get your nice bit of heroin to smoke out of it. You'd put it out on your mirror and just chop it down if its lumpy - you'd probably be getting more than you paid for - then you'd use a MacDonald's spoon to scoop it out, one MacDonald spoon, the little teaspoons, would be a bag, that's what I class as a bag, a Q. Some people would scoop it out and throw it in, what I used to do was scoop it out and level it off, they'd be big enough bags, people would be happy enough with what they were getting. For £20 it would be just one spoonful, it's not much when you think about it ... you'd wrap it up in the little penny sweet bags there's two corners in them you'd just put it into the corner of the bag wrap it up and then do the same on the other corner an' wrap it up. Say you'd have about 50 Qs and you'd put them into batches, then put them into one bag then go off and sell it ... I used to wrap them a few times so if the police come you'd just have it in your mouth, you'd just swallow it and it stays inside you in

the bags [he'd vomit it up after] it doesn't be that big if they're wrapped very compact it'd be only a small ball ... used to sit in the flat bagging all day, you'd be smoking and bagging it at the same time, you'd do, say once a week you'd probably bag for a whole day and then all the gear that's bagged would be sold for the rest of the week.

While the profit covered their own drug use and more, at this level of the market those who succeeded could carve a lifestyle with plenty of 'street cred' in the neighbourhood. Although, a few of the female heroin users were involved at this level it was always through their male partner or family. The flashy gangster trappings enjoyed by a few were highly gendered revolving around cars, women, and exercising power and control over others. As Steve, who became a 'name' in Westtown, described:

I had people, you know what I mean. I bought three cars and I'd be in the back of one and there'd be one in front of me and one behind me. I was like a jelly baby gangster. That's the way it was you know what I mean. You were walking down you'd have a young one this side, a young one that side, and you're the boss. And there'd be gold jewellery wrapped around your neck and you'd be walking round handing out money. You don't have to sell it, all you do is just chop it up and hand it out in batches to the young fellas up in Westtown and they'll sell it for you. I'd be sitting on the fucking wall for bleeding eight hours a day, seven days a week for two thousand pound and I'd only save about a hundred and fifty pound out of it and all the rest would be going into helping others, feeding other people [their habits] you know what I mean. People who'd be sitting beside you keeping sketch for you. Watching out, watching your back and all that. Like if someone owed me money I wouldn't go after it, I'd send someone else after it like especially young ones. All the young ones were dying sick [having withdrawals] and all, throwing themselves at you for gear you know what I mean. I'd say get away here give me it when you get paid and if they wouldn't I'd say to a young one 'see her she owes me twenty pound go up and get it off her' and she'd go up and get it off her. 'You owe twenty pound today, Stevie said he's going to kill you, he wants his twenty pound back give it', you know what I mean. But it's getting a bit crazy this fucking place, people walking round in fear of everyone else. Like you'd be watching your back twenty-four hours every day.

Upper-level dealing

While a few of the heroin users rose to the middle-level of the drugs market, this experience was mainly short lived. None, graduated to the upper level but as JP noted "all the big boys never touch it" but keep their heads down and operate anonymously, as John described:

These were people like that were quiet, people from the area wouldn't have heard much about them or known much about them because they're quiet people you know what I mean like, and like the people that sell it for them aren't going to go round telling people I'm selling it for him, you know. Like they don't do that, that's sending problems back to base, you know what I mean.

Those who had operated at the middle level seemed to have a good sense of how the overall market operated, like a pyramid where the higher up you went the greater the profit you made, or as Brian described it, like a family tree:

If you take a family tree, you know what I mean like he's down the bottom right and he's selling bags, then you have your man here, he's buying ounces off this fella right. This fella is buying kilos off this fella. But the fella who's buying kilos, the trafficker, he'd be bringing it in from Holland. But like the fella mightn't bring it in, he might have someone else bringing it in for him, he's not going to take a chance. Like he's making millions a year. He's not going to take the chance of bringing in a fucking bit of heroin you know into the country. He's paying someone else to bring it into the country, courier it into the country you know what I mean.

The level of profit being made at this higher level was extensive, Sean calculated that:

Conservatively, there's probably eight thousand addicts here using on a daily basis. And when you work out the mathematics behind that, you multiply eight thousand by say forty pounds a day, that's just the minimum any user will spend, you're talking three hundred and eighty thousand pounds, I think the figure is, a day that's been turned over in Dublin, so you multiply that by seven, and there's what, three and a half, three million pounds a week. So where's that going you know, where's that three million pound going, that's what I'd love to know. I mean there's somebody in the banking system here who obviously is aware of it. You know, you can't just hide that kind of money so there's big guys well up in the infrastructure of the way things are here, that know who it is and who they are, so they'll never stop it, they never will 'cos there's so much money to be made and greed inevitably takes over ... most people who sell heroin sell it purely to finance their own habit like and certainly ninety per cent of the people who are involved in the trade are doing it just to survive and then there's the big guys, the ten per cent guys who are making millions of pounds out of it.

There was a certain amount of resentment that the big dealers were exploiting and 'making their pockets fat' from their own people, as Liz described:

The big dealers have the money. That's what my Da do say, it's the cars and all that they're driving, and their lovely houses, that's all thanks to the likes of youse, you know borrowing off them and drugs.

Ironically, however, many of the bigger dealers were unable to use the money they accumulated as it became more and more difficult to launder the vast amounts of money involved, as John related about the dealers in Talltown:

Most of them that have it can't put it anywhere, can't prove where they've got it so ... they move it from house to house, relations and all that, or buy into a businesses like say a shop was making £200 a week and he's saying its making two grand a week

The difficulty in off-loading drug money was magnified in the aftermath of the murder of the crime journalist Veronica Guerin which occurred during the fieldwork for this research. Her death was followed by unprecedented levels of police activity and a large-scale crackdown on organised crime and drug dealing. As David and Peter related:

Ever since the Veronica Guerin thing they've all been sitting very tight because they're all been watched, it's there under people's floorboards and buried in fields, but they can't touch it. [David]

When your woman got shot last year that fucked up the organised crime big time. Like I know people around here who survive on organised crime and fraud. From chequebooks to bankcards to driver's licenses to whatever. That's their family income you know what I mean and she's after fucking everything up you know there's so much attention on all the gangsters, the police they're after stepping up big time on it, on over what happened to her. Like they're running like headless chickens the gangsters are, they don't know who's ratting on each other. [Peter]

The local drugs market

At the neighbourhood level, the most visible aspect of the drugs market was that operated by the user-dealers. This 'dealing' varied from selling informally to friends in their drug network, to having set pitches on the street and customers either there or calling to their home. Some like Ali were cautious:

Ah no, I wouldn't sell it from me house, I never really had to go out selling it, like I never walked around selling it just when I went on little walks. Like I'd be walking to the shop or something and someone would probably ask me have I got it so I'd give it to them.

Others, like Thomas dealt openly on the street:

They'd always know where to find you in a certain place. Like there'd be a lot of people, at times there'd be six or seven people hanging around in one block selling it all at the same time but you'd have your own customers, they'd just go straight over to you. If you'd nothing you'd

send them on to someone else that's the way it works.

In each of the five neighbourhoods, there was one main dealing area. In Westown the forecourt of the local supermarket provided the ideal space as the sellers could mingle and remain relatively obscured by the people coming and going to the shop, although for those 'in the know' or looking to buy, it was obvious what was happening. As Peter described the scene:

It's completely mad, down around there you know below the shops down there is black with drugs. Like you could meet fifteen young fellas, they'd only be about seventeen, eighteen, nineteen. They'd be selling bags of gear, ten pound bags of gear and they'd all have about twenty ten-pound bags on them at a time and there'd be fifteen of them. So it's like a big competition. Like they'd see someone walking up the road 'are you looking for gear?' they'd be all running down, that's the way it is.

In the Northtown area the main sale point was a traffic island in the middle of a crossroads which afforded views, of approaching Gardai, for a long stretch in either direction. In other areas the selling points were in areas accessible to customers but which were also relatively secluded, the design of some blocks of flats and housing estates afforded such privacy in 'defensible spaces', as Ray described of his estate:

You just couldn't get cars out to the place. I mean you could always stand somewhere in Eastown where a Garda can't get you unless they'd run over to you and then you'd see them and run. So it's pretty risk free you know.

However, not everyone was at ease with selling on the street. Frank reckoned street dealing was far too risky and developed his own customer base in less threatening surroundings:

Like if you're selling on the streets though, you're just dealing with junkies you know what I mean, so like, don't turn your back on them you'll get a knife stuck in you, that's the way it is you know. So, they're the type of people you don't want to be dealing with at the end of the day on the streets. And then if you're selling on the street, the Garda know about you, People Against Drugs [anti-drugs movement] know about you, you know, all shit like that. I ended up basically just selling to prostitutes. And like they're all fucking totally reliable, you know what I mean, I mean like they work on Baggot Street and all like that ... I ended up getting a nice clientele, you know what I mean, pretty safe ... like I used to meet them at X on O'Connell Street and have a cup of tea with them and all you know ... You'd always meet people at restaurants or in pubs and all. Have a pint, have a cup of tea, have a chat do your little handshake and then fuck off. You'd be like just mingling in with the general public aren't you, you don't look like a drug dealer, you're not

standing around on the corner like. You know, very sound.

Many of the women user-dealers were reluctant to sell on their own, most sold with a male partner or some male friends in tow and many carried the drugs inside them for safety, as Mary described:

It's amazing what you can fit. You know, powder can be quite condensed and you would fit, not vast, but you could carry a good bit in your body.

For many of the women selling from home was in some ways safer, but doing so brought additional problems like coming to the notice of the police or the Concerned Parents [anti-drug movement] and being inundated with users trying to score, as Joni described:

When I started selling, oh they done me brain in. Morning, noon and night they'd be knocking on the door and oh me Da used to say to me, 'Don't be having them knocking on the door, just don't answer the door to them'. And I said 'but I have to answer the door because if I don't answer my bell they'd be ringing all the other houses to get in'. Ah there used to be killings. It'd be four o'clock in the morning, especially on a Saturday night after the raves. You know, all the ravers coming home and they'd be coming in after the rave and they'd be coming down scoring their Q's and all. So Saturday night it wasn't possible to get any sleep in that flat. So that's the main reason why I got the flat over in X as kind of as a decoy. I used to come over, sell the gear during the day do you know what I mean. That was the main reason that we got the flat, mainly just to be able to go home after we'd do our business. You know the way you go home at night after being at work somewhere else.

Violence and intimidation

With demand high and much profit to be made, the drugs market was a highly competitive business; one that was often violent as customers argued with sellers who fought between themselves and dealers meted out punishments to those who owed money. The user-dealers who ended up owing their dealers money were a prime target for reprisals, as Paul and Simon discovered:

I used to sell heroin, I got bad on it then them when I was selling the gear. You had it there, you'd be getting your batch you'd be getting sixteen keep six, you'd probably get seventeen. The stage I got to you'd be smoking that in five or six hours, you'd put two on [the foil] together, then you'd be taking it out of the profits you'd start smoking out of the profits and then you'd start getting into trouble, then you'd get blanked, and then you'd start getting hidings for not paying back the money you

owe'em. If you wanted to make a profit you could, there's a lot of people doing that but most of us just start getting greedy and start eating into them saying 'I'll work it off the next batch', but it never happens, never works, then trouble starts. [Paul]

All me friends like they'd be buying it off me and like I'd get by with that you know and I'd feed my habit. But I was getting the heroin on tick, and I was getting into debt, and then I got more on tick and more on tick and then that went up as far as two hundred pound. And your man was 'I want the fucking money, I'll come down and smash your house up. I'll come in and kill you, I'll shoot you' you know like that. I was getting threatened and all you know. [Simon]

Dealers also tried various means of intimidation against each other if they felt their business was being affected by another selling on what they considered was their territory or patch. Some of this was small scale intimidation as Rose described how they would argue for custom:

Like there's loads of them selling at Toni's. It's all like 'it's my turn now' do you know what I mean, to sell. You sold it the last time and all.

But the dealing scenes often became violent as people became more desperate to buy and sell. Female dealers ran a high risk of being attacked, as Liz related:

An awful lot of the people that are selling the gear now you'll find are girls that's selling to feed their own habit. And then they're getting beat up and they're getting blades and syringes stuck in them and they do have it in between their legs and they do put their hands down their trousers to take it out you know. One of the girls, we heard, she got robbed and the two fellas actually put their hand down and put their hand up her, like took the stuff out of her and stuck a needle into her arm as well. You know it's not worth it. It's not worth selling it the risk you're taking, you know.

In Talltown, Tim noted that with so many people using and selling rip-offs were more frequent as people got more desperate and the atmosphere more explosive:

Every second person is selling gear whereas before there was only a few selling gear but now everybody is selling it everywhere you go 'are you scoring?', 'are you scoring?' asking you 'do you want gear?' There's more people selling it than there is using it do you know that kind of way so if you add up the users, they're given sixteen quarters, six for themselves, but they have to sell that ten before they can get the next, do you know that kind of way, so they start dipping into them, then you get all people ripping each other off and all that shit. There's a lot of fighting, a lot of baseball bats, there's an awful lot of guns down here ... there's a lot of people that got hidings for things, for ripping off, they wouldn't let you away with it, if you rip them off ... they're going to do it when no one

expects, people are getting taken off in cars and getting bashed out of it ... you'd be took off like up the mountains and held with a baseball bat and left up there to make your own way back down.

It seems that as the potential size of the profits increased so too did the violence, the heroin users talked of gang wars as one group tried to take over another's more successful territory. Brian felt he had a lucky escape when he started selling in Westown outside the local shops and was approached by a bigger dealer who wanted Brian to pay him buy for using this pitch:

I was asked by your man to give him three thousand pound to buy into Toni's [local shop with dealing scene outside]. Like he thought he owned Toni's. Like whoever sold gear there it was all his drugs you know what I mean. Even if it was heroin, E, hash, no matter what it was he had control of it you know what I mean. He was the one that gave it to all of them to sell. So he wanted me to give him three thousand pound and I'd get a cut out of all the profit that was made. I says 'why should I?' I don't know how none of us never got shot and a bullet put to our heads you know.

The drug users who moved onto larger scale dealing inevitably seemed to get caught up in a world where vice and violence were the norm, as Tom related:

A: Like me cousin got shot over it, his kid got shot and killed over it, the main thing is don't touch it yourself and just don't let anyone walk on you, you just have to get your name first like start selling, start getting someone to sell for you, someone rips you off or something make an example out of them, know what I mean like so then the next fella that comes along is going to say 'Jesus look what he done to him over that'. Like X [his supplier] asked me if I wanted a loan of a piece to do something 'cos someone was after doing something on me.

Q: Would it be easy enough to get a piece if you wanted?

A: Sing a song and you'd get one, it's that easy, you just have to know the right people, like I got offered a sawn-off shotgun for two hundred pound.

The prescribed drugs market

In addition to the user-dealers and the illegal drugs markets, a substantial trade in prescribed medicines developed from supplies stolen from pharmacies and accessed from a number of rogue doctors who were liberally prescribing physeptone/methadone, benzodiazepines etc. At the time of the research study there were few controls on GPs prescribing methadone and at the same time few methadone treatment places available. Consequently, there was a large illicit market

for methadone for people who used it 'to sort themselves out' or to do a home detox – the latter often involving parents of heroin users seeking methadone on the streets to help their son/daughter come off the drug. While most of the heroin users would have been entitled to free medical care and free prescriptions on their medical card, many of these GPs, whom Simon called "legalised drug pushers", charged the heroin users both for their visit and their 'script', but then not everyone was a genuine patient in that some intended to sell on some, or all, of their prescription, as Tom described:

Some Doctors, I was on, they'd put the Phy [methadone] on the prescription, on the medical card for you, and some of them won't so you'd have to pay your £40 and then it would be £15 to see him, but you'd make all that back because its £5 for 10 mls of Phy, £10 for 20 mls and there's a 1000 mls in a bottle, so you'd more than double your money back.

Many of the heroin users described the intricate lengths they, and others, went to in order to access supplies through a number of GPs and then use the scripts to cover their own needs and make a profit out of the rest. For those who were successful, such as Sarah and her partner, you could carve out quite a lucrative business in this way:

700 mls [of Physeptone] I used to get off him 'cos you see what we done was, we had him and we had another doctor, and the other doctor was writing us out 120 Rohypnol a week and he was writing us out 1400 mls each, so we had 2800 mls, and we were getting 120 Rohypnol and 120 Roche a week 'cos we were on three different doctors, do you know that sort of way. So we'd have to go to two different chemists you know like and interchange the two ... You go in like say once a week and you got your Phy. So 120 Rohypnol is supposed to be a monthly thing. Like what I'd get is sixty and me fella'd get sixty so it'd be 120 between two of us. But that's supposed to be monthly scripts that he'd be writing out but he wasn't, he was writing them out on weekly scripts, do you know that. So like that was when we really got bad on the Rohypnol and things. He was a private doctor you know that sort of way, how we caught onto him was, 'cos we missed our doctor over you know the holidays and we just chanced him by arm and I said, 'no he won't give it' and we went in and he just wrote out the scripts, he was writing out all the things and it was 'this is great'. And I said 'will I come to you next week' and he was there, 'yeah, yeah'. So we had all this Phy and we used to sell it then like 'cos we were taking the gear as well at the time so we were selling the Phy and we were taking the gear [heroin] and we were keeping the tablets for ourselves.

Since this fieldwork was conducted, strict controls on the sale of methadone have

eradicated most of this market, although the market for benzodiazepines continues to be strong. At the time, though, the sellers in the 'benzo' market were not all heroin users, many pensioners in the area were also selling their sleeping tablets to make some extra money and a lot of 'benzos' circulated among family and friends. Certainly, groups of people hanging around the local pharmacies in the area could be seen to be buying and swoping a selection of prescribed medicine, as Charlie described:

You'd get Roche [Valium] anything these days if you know the right people to get them and where to get them, round Southtown just walk down the road wait outside the chemist, get anything you want, Napps, Phy, Roche, Dalmane, gear. Used to walk down there and see queues all sitting around waiting for them to come out of the chemist with their prescriptions, the junkies just walk off then down to the park and you'd get what you want off them. They'd be getting on prescription Roche, purple hearts, Phy, speed tablets, anything you can get a buzz out of, they'd be getting them. I know fellas that's going to five or six different doctors a day paying a tenner to each doctor and getting a script off each and then selling them, making a right few quid at it.

Contact with the Criminal Justice System

The possession of illegal drugs, the theft and sale of goods, and the sale of drugs to fund the cost of their habit, inevitably brought the heroin users into contact with the criminal justice system, as Sean related:

I was busted in the end, I think everybody is sooner or later, if you're a user you're going to end up in jail or in the courts definitely and I certainly did.

Once you become known to the police, as Frankie experienced, arrests were commonplace:

Once the Garda know your face they keep bleedin' arresting you all the time.

Sinead, who became well known to the police, related how she was constantly being arrested for her activities:

I started selling gear to other people and I started getting in a lot of trouble with the police. I started getting arrested, brought down the station for drugs searches and me house getting pulled apart you know looking for drugs, and I got arrested one time for fraud. You know, I'd no money for drugs one day, and I went in and I changed a cheque for sixty pound. And I just, I got arrested on it and what happened was, I actually got away with it 'cos it was me first charge but this was

constantly going on. Police arresting me in the street, always being in trouble, always getting arrested for some thing or another that I'd be doing.

For many, life came to revolve around police raids, getting charged, dealing with arrest warrants which could hang over you for years, being put on probation, into prison, out on temporary release (because there's not enough prison places), and going 'at large' - on the run. Some complained of being beaten up and being 'stitched up' by the police, or being used to get information on others. For Brian, who was well known to the police for his dealing activities, life became a constant battle of wits to avoid arrest:

I used to have to get up at half seven every morning. To wait for the police to come. Police always raid your house at ten to eight. They sit outside the house at ten to eight you know what I mean and everyone knows so you'd be up at half seven standing in the house watching and next thing if one police car came down the road I'd be out. Over the back wall and gone. Like I had to do it a few times, jumping out me window and everything ... I'd be just in between all the houses like I'd be dodging the police and I'd be dodging them and dodging the fucking vigilantes and I was running from everyone you know what I mean. The police on me back and the vigilantes after me kneecaps and these cunts after me head ... and loads of times the minute I'd walk down the street I'd be pounced on by the police. Dragged into the car and handcuffed to two people so I couldn't move me hands. One copper would keep his hand on me throat so if I had it in me mouth I couldn't swallow it or anything like that. 'Where is it?' 'Where's what?' 'Where's the gear you were bringing over there to Toni's?' 'I wasn't bringing anything over to Toni's'. He'd say, 'you were, we know you got a phone call ten minutes ago by a fella named John'. And I'd think them cunts are after setting me up.

While their encounters with the police were often traumatic, for the heroin users the court system was incomprehensible and totally alien. Summons were produced to see if I could understand what they entailed [I couldn't] and they talked about the experience of being in court and not being able to understand the language of the judge or barrister and the feelings of humiliation they experienced. Others, however, became extremely knowledgeable about the criminal justice system and adept at getting warrants struck out, plea bargaining etc. Rose, for example, was able to get out of her many charges by giving false names:

Every time I got caught robbing I never used to give me own name. There's these three young ones I know and they're not into anything but I know their name, their address their date of births, their fucking ma's name before she was married, everything. So I was using them for a

while, and it takes, it takes about a month or two for a warrant to come through, so just say if I gave the name today and I got caught robbing then the next day, I'd give the same name you know what I mean. I wouldn't go to court for that one but it wouldn't be up on the files yet. So you could use the same name for a few days, for about a week or two and it wouldn't be up as a warrant do you know what I mean, 'cos it wouldn't have come through. But, I ended up having to give me own name, I ran out of names, do you know what I mean.

Prison

Overtime, it was almost inevitable that many of the heroin users would end up in prison, for either robbing, possessing or dealing drugs. For some, prison offered a respite away from the chaos of their lives as heroin users:

Sometimes I think that you can get your head sorted out when you're in there. Like some days I wish I was in there instead of outside. 'Cos in there your life is controlled for you and you know what you have, all the problems are outside and you're in there like and no one can hurt you anymore. [Masie]

See I'd rather be in the Joy [prison] than be homeless you know what I mean. [Karen]

Similarly for Terry the prospect of even a long sentence appeared better than his present life:

This sentence now I'm expecting the longest, like to get three year I think. Like I don't really mind like, it's better in than out the way it is.

Many of the heroin users effectively could spend most of their lives moving in and out of prison, as Kieran described:

When I started going into prison I was sixteen, like nearly all my life was locked up in prison you know.

For some a prison sentence offered a chance 'to get their head together' and get clean (see Chapter Nine), for others though a sentence did not overly effect their drug-using career as drugs were available within the prison, as Anthony related:

like the drugs is still getting in and out of the prison, people are going for days out, or weekends out you know what I mean, and bringing them back too inside them. Or getting them passed on a visit through kisses. The hardest thing to bring into a prison is a syringe or a works. A lot of people that get it in, that know they're going to court and might get a sentence, would put them up themselves, you know what I mean, as far as they can get them up. 'Cos like you don't get a proper search

you know like what you'd see on the telly, you don't get a drugs search you know what I mean, you get stripped alright, but they only see if you've tattoos or scars or anything. And in prison like, they don't, I don't think they do care too much about it.

In fact, there seemed to be a tolerance about drug use in the prison, as a way of keeping the inmates pacified, as Pat described:

The screws they turn a blind eye to it, because it's actually keeping them quiet, do you know, and they're not going to disturb somebody, so why should they make life harder for themselves.

Impact on the neighbourhood

The drugs market and all its manifestations as outlined above had a profound impact on the neighbourhoods. The sheer concentration of users and sellers congregating in the dealing areas was visible for all to see. Sometimes a small group but at other times 20, 30 or more would gather selling, waiting for a dealer or just killing time. Walking around the neighbourhood you soon became aware of the tell tale signs of who was doing a deal, who was waiting for a dealer to arrive or who was using:

Word gets around like wildfire you know. But as soon as you see a load of junkie looking people hanging around you know whether there's something going on you know. Or taxi's pulling up outside places and that. [Joe]

At times [in the flat complex in Southtown] they'd be thirty, forty people buying drugs, if you were waiting on somebody to come back with drugs you'd see it, people going into buy drugs, an awful lot of police around, an awful lot of taxis driving in and out, always a lot of people, police driving in and out of the flats, crazy scenes, still can't catch them, it's mad, like you'd probably get one copper just walking in and moving everybody on, but you'd just walk back a few minutes later and the dealers are there waiting for you to come back. [Thomas]

The 'open' nature of the drugs market in these areas, where buyers could approach or be approached by sellers, attracted users from other areas where the population of heroin users was insufficient to sustain a market and, consequently, local supplies were erratic. In areas like Westown the quality of heroin was perceived to be better, the price lower, and with a greater number of sellers there was less likelihood you'd have to hang around waiting for a dealer to arrive while your 'sickness' worsened. But it wasn't just buyers that were attracted to the area, sellers too knew there would be a market for the produce and the quicker they could off-load their goods

the less risk there was of them being caught. The combination of buyers and sellers drifting to Southtown amplified the problem in the neighbourhood, as Mary found:

Most of them that do be in the flats aren't from the flats, know what I mean. Like they're all the junkies coming down looking for gear. And then all the ones that are selling it know that they're all going to be there and they're looking so they'd be down in the flats selling the gear. Once they're selling gear, they know that everyone goes after them looking for gear so they go down there and sell it. And then all the ones that's on gear know that they'd be there selling it so they're all in other flats you know what I mean. And if there's nobody there selling gear they wait 'cos they know someone will come with gear, you know that way.

The multitude of buyers and sellers in the neighbourhood creates a high level of disturbances in the areas. Although, a decrease in the supply of heroin leading to a scarcity at local level can be even more problematic. The shortages in supply which occurred during my period of fieldwork, as a result of major police investigations, produced some incredible scenes in the neighbourhoods, Peter regarded these scenes as:

Complete madness, at the moment like, there like for two weeks, there was no heroin in Dublin. And if there was it was parked off and no one was touching it because like the people coming and driving up here from all over the city - 'Any gear?' 'Any gear?' - Swear to God, and this was up to half eleven, half twelve at night. So they're coming out after being driving all over bleedin' Dublin. I was going through Westown, at the same time, about two or three weeks ago, and there was about nine hundred people lying on the field over waiting on drugs, and there was none. It's madness.

Interestingly, the drought highlighted that it was not just locals using, or other working-class youth, but that there were a number of middle-class users who were brought to the surface when their usual supplies dried up, as Rose noted:

There is people strung out everywhere, 'cos like say during that drought like you'd see people up here from fucking everywhere, you'd see people coming up here like there's a lot of people strung out from all different areas, posh areas and all, but there's probably not much selling it out there do you know what I mean. But you come as far as you can to get it, do you know what I mean.

The dynamic of local drugs markets

On the surface, the growth of a local drugs market requires, in addition to the laws of supply and demand for that good, a market place where it can be retailed, and the

obvious location for this is where the demand is greatest i.e. in the neighbourhoods where use of the drug has been growing and there is a sufficiently large population of users or potential users. However, not all of these neighbourhoods will facilitate a heroin market, a further necessity for the market to take root in an area is the availability of a safe selling point for all the user-dealers. Individual houses are not suitable as they restrict the number of dealers, and anyhow user-dealers just want to operate on a part-time basis making sufficient money to cover their habit and then go and use themselves. Higher level dealers don't want the risk of being approached by all the users in the neighbourhood and anyhow they prefer to make their profit cutting up the drug and selling 'batches' (sixteen bags) to the user-dealers.

However, further interpretation of the data indicates a more complex dynamic occurring. As noted in the previous chapter the availability of heroin was a key factor in developing a heroin career. With more frequent use comes the need for sufficient funds to cover the cost of your habit and, as seen earlier in this chapter, low-level dealing became the most suitable means of doing this. In this situation, involvement in the drugs trade was seen to lead to an escalation in use, and a consequent growth in demand at a local level. This in turn attracted outside dealers and buyers who added to the level of disorder in the area.

In addition, for markets to develop locally there was the physical requirement for 'defensible spaces' where they would be relatively undisturbed. However, rather than this being a question of anti-social behaviour being tolerated, for this was not the case as, at the time of the fieldwork, a massive anti-drugs movement led marches through and patrolled known dealing areas. Instead, it seems that poor people living in poor places have a particular relationship to local public spaces. Small living spaces and large families have traditionally necessitated that more time is spent outdoors, and 'hanging around' and street games are part of the fabric of life. In this context, groups of young and older people buying and selling drugs are not so immediately obvious. In addition, in areas of predominantly public housing there tend to be more public spaces and derelict areas than in areas of private housing where ownership is more clearly defined, land more expensive and space is at a premium.

Conclusion

In this chapter the nature of the local drugs market has been explored and the existence of an informal economy is seen to have facilitated and benefited, albeit if only initially, from the development of a drugs market. Heroin users were seen to become involved in dealing mostly at the lower level to feed their own habit although some moved into middle level dealing even though they were unlikely to make a success of this while using the drug. Nonetheless, their involvement at the lower end of the drugs market added to the buzz and the attraction of the lifestyle and provided structure and routine to their lives where few opportunities existed.

However, there was a certain degree of inevitability as to how their drug career would develop. As their lives became more chaotic, their contact with the criminal justice system became more frequent, and they both experienced and delivered violence and intimidation. The irony of the situation was that through their heroin careers they provided the equivalent of shop floor workers for a multi million pound industry and benefited as little from this as they did from formal opportunities in legitimate markets.

The impact on the neighbourhood was multifaceted, visibly open drug markets added to the level of disorganisation in the community and as the accompanying intimidation and violence erupted, heroin came to dominate the minds and lives of those living in the neighbourhood.

Chapter Seven

Education and Employment – legitimate options and opportunities

Introduction

Chapters Four and Five, respectively, provided profiles of the neighbourhoods and the heroin users who participated in this study. These mainly quantitative profiles were qualified by the narratives of the heroin users who described the experience of growing up and living in these neighbourhoods and the development of their drug careers in this context. The issue of neighbourhood context was explored further in Chapter Six, where the operation of the local drugs market was examined and the issue of illegitimate opportunity structures explored.

In the three remaining data chapters, the focus of attention shifts somewhat to the options, opportunities and support that were available to the heroin users in their neighbourhood. Here the issues of education and employment; family and relationships; and drug treatment options will be explored. As heretofore, the heroin users' experience of each issue will be located in the context of the neighbourhoods in which they live and operate.

In this chapter, the aim is to explore the heroin users' legitimate options and opportunities through the education and employment systems. Their educational experiences and outcomes and the factors which affect these, such as home, school, behaviour and drug use are examined. In turn, the impact of educational outcomes on employment opportunities is assessed.

The Irish education context

In Ireland, children typically attend primary school for eight years from the ages of five to twelve; pre-schooling is not provided by the state. Secondary level schooling is normally a five year cycle with two main examinations the Group/Junior Certificate, usually taken in the third year - the minimum educational qualification available - and the Leaving Certificate taken in the fifth year.

Children leaving school at or below the age of fifteen are designated as early school leavers. Nationally, approximately a third (35%) of the population are estimated to be early school leavers (Gamma, 1998a-d). However, in the drug neighbourhoods included in this study these rates were higher ranging from 36% to 72% (see Table 4.1).

The link between early school leaving and socio-economic background has been noted in a range of research studies. For example, Clancy's (1995, p485) analysis of data from the School Leavers Surveys showed that of the 22% of students leaving school before Leaving Certificate stage, only 3% were from higher professional families, while almost half (47%) were from unskilled manual backgrounds.

However, early school leaving is also accompanied and preceded by chronic school absenteeism, which is much more difficult to quantify. McSorley's (1997) study of school absenteeism in the Westown area shows a problem so acute that up to one third of the school-going population were absent from school on a given day.

Both early school leaving and chronic absenteeism, in turn impact on education outcomes which also show clear class disparities. For example, Whelan's (1994, p137) research showed that while 82% of the professional managerial class hold a Leaving Certificate or third level educational qualification, only 2% of the lower working class do so. In addition, while an average of 8% of 1980s school leavers were unqualified these were found to be largely concentrated in disadvantaged areas (European Social Fund, 1996, p40), where, as has been noted earlier, heroin problems are also concentrated.

The impact of these high rates of absenteeism, early school leaving and low levels of educational qualifications on employment opportunities and, consequently, on the extent of disadvantage in the drug neighbourhoods, will be discussed later in this chapter. First, however, an analysis of the in-depth interview data reveals the heroin users' perceptions and experience of the education system.

The education experience

The high rates of early school leaving in the drug neighbourhoods indicates that this

is a general phenomenon in the area, not just related to the heroin users, as Christine described:

People that I knew from school probably got up to first year in school and that would be that, they'd be gone. A lot of the people that I used to be with, I'd say third year would be the limit there you know ... most of them leave around first year and like a few would leave around third year.

However, while overall rates in these neighbourhoods are higher than the national average, the rates of early school leaving among the heroin users who participated in this study were even higher. As noted earlier in Chapter Five (see also Table 5.6, Appendix 5), three-quarters (75%) of the heroin users were early school leavers – 78% of the females and 69% of the males. In addition, while a higher proportion of the female heroin users were early school leavers, more males than females – three-quarters (76%) compared with almost two-thirds (62%) - left school before taking their Junior/Group certificate examination i.e. left without any qualification. Only 7% of both the male and female heroin users had a Leaving Certificate qualification; none had a third level education or qualification. Furthermore, over a quarter (27%) of the male heroin users and nearly a third (30%) of the female heroin users reported chronic absenteeism before leaving school.

This data indicates a possible link between early school leaving and developing a drugs problem. For, conversely, those few who remained in school were seen to rarely develop drug problems. As Ali noted of her peers:

Like half them like they're still in school and they're not on drugs, the other half either have kids or they're on drugs.

Tricia similarly related:

Of the people I knew in school, two stayed on. One is still there, one is doing their leaving this year. Everybody else left and is working or, is still - like most of my friends are - still strung out.

In the in-depth interviews, the heroin users spoke about their experience of schooling and the factors which had impacted on their attendance. For the purposes of clarity, these will be discussed under four broad categories - home, school, behaviour, and drug use. However, it should be noted that these factors rarely operate independently of one another, but, as shall be seen, are inter-related in a number of ways.

Home factors

McSorley's (1997, p47) study of school absenteeism found young people experienced multiple stress factors in the home such as unemployment, poverty (lack of money to buy school clothes etc. and lack of food and heat), parental separation, single parent care, depression, violence, addiction, illness, imprisonment and death. There is, the author notes "a huge discontinuity between the stressed conditions of home and the structures, expectations and content of school" (ibid: 47)

Some of the heroin users, such as Kelly, related how problems in the family home impacted on their attendance and behaviour at school:

I was disruptive in school. There was a lot going on at home, there was violence in the home and there was, you know, there was drunken screaming and shouting every night and I would have opted out.

However, Kelly's response of 'opting out' contrasted with Joni who found school provided an escape from family difficulties and she remained at school until she was sixteen, after completing her Group exam:

I used to actually love going to school 'cos it meant getting away from the house, it meant getting away from me mother and me father, it meant getting away from them, so I always wanted to go to school like to get away from them.

Family finances also played a role in whether the respondents' continued on with their schooling. Drudy and Lynch (1993) stress the (neglected) explanation of poverty in explaining class inequalities in educational participation and achievement. While second and third level education is provided free, meeting the associated costs of participating in education creates difficulties for families on a low income. As Maisie observed:

I mean okay, education is free yeah but what about uniforms, lunches, bus fares, books, there's a certain amount you can get to help but there's not a lot.

The paucity of the financial support available for meeting participation costs was noted by Angela:

I mean I know you get a back to school grant but what you get for the back to school grant, doesn't cover - I think you get thirty-five or forty-five pound, I can't remember what it is - that'd pay for one pair of runners [sneakers].

In addition to the participation costs, there was also the opportunity cost of missed earnings. Katie's incentive to leave was to earn her own money for social activities, as no one in her family was working and money was scarce:

I left when I was fifteen 'cos all me friends had a job and I'd none and like I was asking me Mammy to have the money for the weekend to go out and none of them work so I just left meself when I was fifteen, me Ma wouldn't let me leave 'til I had a job. So when I got the job then I left school.

However, as will be discussed later, the few jobs that were available to early school leavers with few, if any, qualifications were poorly paid, insecure and offered little opportunity for development.

McSorely (1997) had also noted a major element in absenteeism was parents' willingness to keep children at home for family duties. Older, in particular female, children were often required to work in the home to help with younger children, as Ellen and Jessie had experienced:

I made me confirmation and I left in second year. When me mother got that [prison] sentence, I left school. I never done any Inter [Junior Certificate exam] or anything. ... I was doing the housework and getting the shopping and going up and visiting me mother and getting stuff organised you know. [Ellen]

I was never in school ... it was just the eldest didn't go to school, me Ma and Da worked and I minded the kids and sent them to school ... from when I got up in the morning I got the kids out to school, cleaned the house, watched the telly, got dressed and I'd go out get the dinner, then the kids came in, then me Ma and Da came in, that's how I was always treated. [Jessie]

This tradition of female children working in the home may help to explain why they have higher rates of early school leaving than their male counterparts.

Parents' complicity in their children's absenteeism from school (as distinct from truancy where they are unaware the child is 'mitching' is worth noting in order to understand the processes involved. McSorely's study (1997) had noted that school personnel viewed parents, who are themselves socially and educationally disadvantaged, as lacking the economic, academic and emotional resources to ensure their children are up, fed, dressed and with homework properly done and uniforms, books and lunch all ready in time for the school day. However, few of the

heroin users' parents were seen to actively sanction their absenteeism, many were misled, as Ali related:

I was always on the hop but I always went to me friend's house right at the back of me house, I used to hide and we used to always say we missed the school bus and we were sent home 'no school' - like we'd say that to her Ma.

Many parents did not realise the extent of their child's truancy, as was the case with Rose's parents:

Yeah, I was going to school when I wanted to, you know. Used to get up every morning to go to school but I never really went. I'd get up in the mornings and go, 'cos me Ma would kick me out to school but I never went.

Others related how parents or older siblings tried to ensure that they attended school, however, their intervention was not always successful. As Anthony described:

I stayed one year in secondary school. Then I left after that. I just didn't like it know what I mean like. Me parents and all didn't want me to leave school but I just never went in. They thought I went in but I just never used to go, and eventually like, me Ma got a letter saying that I hadn't been at school in two months and she thought I was going to school every morning. And she'd say 'you are going to school' and I'd be going 'I'm not going to school' and all. And I was coming up to 15 and I'd be saying 'sure when I'm 15 I'm leaving anyway so I'm not going to go'. And she'd still say 'you are'. And the school was right at the back of the flats where I lived so, what I used to do was, I'd go in, she'd walk me round like, and I'd come in and I'd be in playing ball and I'd go out the exit, out the back and back into the flats and I'd go dossing into town and that, go dossing off somewhere until school was over. And she'd think I was in school you know.

School factors

Both McSorley (1997) and Drudy and Lynch (1993) have noted that the academic content and organisational structures of school do not meet the needs of poor and disadvantaged pupils. Consequently, one of the main reasons for leaving school are often school related.

Nearly all the heroin users, such as Cathy expressed a dislike and disinterest in school:

A: I was mad in school. Do you know, real cheeky and never got on in school do you know. I used to go on the hop from school and take drugs do you know. I didn't want to know anything about school or stuff like that or jobs.

Q: And what was it, the teachers in the school or the things you were doing?

A: The things I was doing, you know, English and Maths and all. I wasn't into it. Just didn't like it. Yeah, I was getting thrown out, and suspended and expelled, you know. All stuff like that. No, I never liked school, I'd no interest in stuff like that you know.

This disinterest in school was seen by O'Neill (1992) to be related to the alienation from the school system experienced by working-class parents and early school leavers, the vast majority of whom felt that schoolbooks did not reflect working-class lives and that teachers did not understand working-class people.

The chasm between a middle-class oriented curriculum, taught by middle-class teachers, was seen to have little relevance to everyday life in the drug neighbourhoods and served to deepen the feelings of inadequacy of the pupils from these areas:

I was in the honours class but I didn't, I didn't quite understand it. They were always just pushing you to work and work and work, but, what's Julius Caesar going to do for me when I get out, do you know what I mean. I didn't understand it. Why don't they teach us, like I think honestly I mean I educated meself like through experience and things, I have me own education through experience of things in real life and I mean I didn't grow up on the streets like but I've learned from the streets, do you know what I mean. I've learned like and I'm educated from them. And I don't think I'm a dunce, do you know, I don't think I'm a dunce. [Joni]

Like I went into it [school] knowing nothing and I came out knowing nothing. You know like they say you've to listen and learn. I used to listen and learn the best I could and I still never learned anything, still came out as dull as I went in. It was up to meself to learn something you know what I mean. [Brian]

Many of the interviewees had literacy difficulties, such as Sharon who admitted that she "can read a little bit but I'm not brilliant". Such difficulties were seen to contribute in turn to chronically poor attendance levels which further exacerbated learning difficulties:

I started getting bored with school, and started falling behind, I wasn't very good, and was always in the remedial class, so I started mitching from school and getting involved in drugs. [Paul]

I was always on the hop. When I left school, I was fifteen, but I never done any exams or anything like that you know what I mean. I spend

more time playing truant you know that way. Just used to go up to the fields, feed the horses and that you know what I mean, buzz around all day. Then me brother started coming after me, you know yourself. So I sort of finished me last, the last year in school, third year. But I never done any exams or anything. Sure when I got any results they were just all noughts and everything you know what I mean that way. [Jack]

However, it would be incorrect to equate all such difficulties with lack of ability. While some of the heroin users perceived themselves as having learning difficulties - perceptions which the school system and some teachers had fostered and reinforced. The vast majority of those I interviewed were articulate people - with an unnerving capacity to quickly calculate the potential profit on any quantity of drugs - whom the education system had failed as much as they had failed the education system. Many, such as Annette were adamant that their difficulties with school were not related to their ability:

Q: Did you ever do any exams?

A: No, never done anything no. And I could do the work like I was, like I was intelligent enough to do the work you know. I just didn't want to put an effort into doing it. That's what it was. I didn't care, I just didn't care.

As Frank commented:

Like I didn't leave school 'cos I was stupid or anything you know, just like I was stupid for leaving school but not because I couldn't handle school you know. Just don't know, got a bit of a wild streak in me or something you know what I mean.

Behavioural factors

In addition to chronic levels of absenteeism many of the heroin users reported high levels of disruptive behaviour, by themselves and other pupils in the schools. Donal didn't feel he was going anywhere in school, and wasn't interested, he reckoned his local school:

It wasn't a good school - there was messing going on all the time, like there'd be 30 or 40 in the class, and half them would be shouting around the classroom.

Schools responded by suspending or expelling the pupils which contributed to their absenteeism, early school leaving and education outcome, as Frank described:

Yeah I got thrown out when I was thirteen. I purposely got meself thrown out you know. Fighting with teachers, going into school, then

just legging it if it was nice out, going into town and not coming back.

Disruptive and violent behaviour in the classroom was particularly prevalent in the boys schools and was explained by the heroin users as stemming from frustration and a response to teachers who were perceived as being difficult, as Paul related:

It was a big class alright, some of the teachers you wouldn't get on with, times when you'd do some nasty things if she had her back turned you'd give her a slap with something, if she was after showing you up in front of the class or something, acting the hard man really, there was a good few of us always in trouble, having your Ma down in the school every second day, gets to stage when you either leave or they throw you out, so I just ended up leaving, wasn't even half way through first year, no education at all although I can read alright, I'm not bad at reading and writing.

Tom had a volatile school career, he started 'mitching' when he was seven and even though he stayed in school until he was sixteen, he left without any qualifications:

Me Ma didn't really give a fuck [stressed] about us so I was able to do kinda what I wanted, I mean I'd mitch from school she'd catch me keep me in but I'd just run out, I always done what I wanted, wouldn't let anyone stop me. I liked school, didn't mind it, but as I got older there was always better things to be doing than going to that place, didn't think what it would do to me when I got older, I just kept on going on the mitch, running amok, getting suspended, expelled, I got fucked out of a few schools and when I went into secondary then I got fucked out of there so I just left it, blanked school then.

In a few cases the pupils ended up being sentenced to juvenile detention centres, as had Charlie:

I was good at going to school when I was in primary, 'til three days before I was to leave. I think I was bullying someone, something was happening. And the teacher came over and clouted me and I gave him a box and I got expelled, three days before I was to leave, I got bleeding killed. Me Ma killed me, me Da. So I went to secondary school and in secondary school I was a rebel big time, I wasn't into it. So that's when I got me two year, a sentence of two year in Trinity House [juvenile detention centre].

Drug use

Some of the pupils' disruptive behaviour was related to drug use, as David recalled:

There was a lot of fighting started in the school 'cos of the hash, 'cos like there was people, there was people in the school and they were you know they weren't into it, just drinking heads and you know they used to always say, look at the druggies, look at the saps and all, and by the

time I got into third year my year was more or less, you could say they were running the school. Well not running the school but we all used to sit in the shed and no-one really ever came near us except people that were you know, just one of us. But then in third, towards the beginning of third year we started to fight a lot with the older, you know the sixth years, and I remember getting suspended so then we would all go on the hop, bunking off school and getting caught for it and getting suspended and just, it was more or less from smoking hash we just all, we just all forgot about school.

Many of the heroin users had experimented with alcohol, cannabis, LSD and solvents while still at school, a quarter had been regular users of illicit drugs and had tried heroin. However, three-quarters did not start using heroin until they had finished with school (see Table 5.14, Appendix 5).

For those who were using drugs, this was an additional factor contributing to truancy, as Marie related:

A: I didn't go every day, I'd just go, mitch from school do you know.

Q: Yeah, and would a lot of you go mitching or?

A: Yeah, yeah eight or nine of us.

Q: And what would you do for the day, where would you go?

A: Go up the road and buy cannabis, just sit in the park.

Q: Right yeah, and did you ever get into trouble or?

A: How do you mean?

Q: I mean if you were hanging around during school hours, did anybody ever?

A: Like police or anything like that?

Q: Yeah.

A: No, I always used to put my tracksuit bottoms in the bag you know. Take me uniform off me and put them on me.

Frequent drug use also contributed to early school leaving, as in Annie's case:

I started smoking hash in school, it was funny like, coming out after school and we'd go for a joint, then we'd go home, have our dinner, get our homework done, come straight back then. Our whole life like revolved around drugs. I was a little E monster, every weekend do you know, you'd do E and everything. And then it came to my Leaving Cert. I left school two months before my Leaving.

Indeed, it was those same students who had experienced alienation and feelings of inadequacy while at school who using drugs at this early stage. As David described:

Q: In the school, how many would have been smoking blow [cannabis] frequently?

A: I'd say about a third. Well all the, say the good students in the class wouldn't, they'd be more or less, they'd be real you know, they'd just try and do their work and all. It wasn't just the messers but it started off with them then worked up to the sort of the middle of the class, the people that could understand what they were doing but weren't great at it, like meself. Then it went just went to say about a third or a half of the class, say if there was twenty five in my class there was about twelve of us that used to smoke, we all used just sit down the back of the class.

Difficulties in coping with school were not the only factor contributing to school drug use, for some, like Sinead, had been doing well until she began using drugs regularly and then:

I became very disruptive in class, I used to be causing murder in the school. I used to be getting reports home all the time. They couldn't see what happened 'cos it was like I was doing so well in school up until I was in fourth class until I started using. And then me grades started slipping and I started slipping. And me Ma used to be calling round to the school ... and then when I was fifteen I left.

Others, such as Pat, were anxious to dispel the myth that all heroin users were unqualified and uneducated:

It's not as if, and I've the education behind me, but you get these people saying well, it's the less educated people that are taking drugs. Like I don't consider myself as stupid, I don't consider myself as brainy, but I've done my Inter and I've done my Leaving [exams] and I've passed both of them and I have qualifications.

Many, such as John spoke about how they perceived their drug use, and that of others, as an escape from the harsh realities of their lives:

Most of the people I hung around with in school they were just, how would you say, existing from day to day. Just doing whatever like they'd get up in the morning with no idea of what they're doing or, I'm going to school, what am I going to do in school. So like when there was drugs in school it was great you know. That's the way a lot of people in the class looked at it ... I think it was just a way of getting things out of your head, you know, just forgetting about things you don't want to think about or you don't want to talk about, you know, just things like that.

From the perspective of those interviewed, their schools appeared to have little realisation as to what was happening, as David related:

They hadn't a clue, I think they just put it down to the usual teenage problems, people getting into trouble with their parents and coming into school and taking it out on the teachers and all.

Few of the schools provided drugs education, as Angela related:

I approached the headmaster in her [daughter's] school and they have no drug programme in the school and I asked about one being started and he said oh there was a programme coming out from the Department of Education, but they would have to wait until it was issued by the Department and it would take in from first class up to sixth class. Now the kids going from the national school into the secondaries and the vocationals, they haven't got a clue. Like they're street wise, they know what a Q is [standard retail unit of heroin], they know what an E is, but that's street education, that's not proper education for them.

However, in the few schools where drugs education was provided, such as Christine's, those who had already begun to experiment with drugs found the whole exercise risible:

Sure we used to get told about that in school but, we'd be taking drugs at the time, so we'd be laughing at them and saying you haven't a clue do you know what I mean ... some of them really now you'd even laugh at them yourself. I remember the one good one we did was they did a play and that was good. But still, didn't get anything out of it. Just thought it was great 'cos we were out of class for a half an hour and it was about drugs and it was real interesting, but not taking the danger out of it, do you know what I mean, looking at the negative bit of it and laughing at it, like it wouldn't play on me mind at all. Well, just speaking for meself I'd have taken no notice of it, do you know what I mean and giving out books and all I don't think it does anything. I don't think there is a thing that they could do, you know what I mean, for me anyway, people could talk to you I'd say 'til they're blue in the face.

Responses to education difficulties

As has been demonstrated, pupils' home and school lives, their behaviour and drug use all contributed to their performance, attendance and duration at school.

However, there appeared to be few 'safety nets' in place to prop-up those who experienced difficulties in these areas.

In the case of students experiencing learning difficulties, schools responded by keeping students back for a number of years, particularly at the latter stages of primary schooling. For example, a number of the interviewees were still in primary school at fourteen years of age while the average age of leaving this cycle was twelve years. Mark had been kept back in the final year of primary school for two years and then left without ever going into second level education. When I met him, aged eighteen, he was in a panic over a court summons he had received which was

written in formal legal language with some scrawled comments which were almost indecipherable, as I helped him with this he recalled:

I done sixth class for two years and that was it, I never went back that was me last education ... apparently I'm not very good at say, spelling or reading or writing but if I pick up words and look at them and break them down I'll get them, you know what I mean.

Pupils who have difficulties reading and writing at the end of primary school, found the transition to second level, where they are studying eight or nine subjects under different teachers, very difficult and a rapid deterioration in attendance rates tended to follow.

However, while enforcing school attendance was the responsibility of the School Attendance Service in Dublin city and the Gardaí in the suburban areas, neither was found to be very effective. Poor attendance is supposedly followed up by home visits, written warnings, legal warnings and ultimately the issue of a court summons. This process was seen to have an impact on some of the young people's attendance, as Donal described:

I used to take the odd few days off but usually turned up - they were quick to pick up on lads who mitched.

Others, such as Marie, found the system ineffective:

A: They'd just say I was having a last chance and if you miss any more days from school you'll end up in court, I never listened to them you know.

Q: And would they give your family a hard time?

A: Yeah, but they just keep coming out and saying the same thing, over and over again.

A further problem with this service was that by the time the legal process was put into action, many of the pupils had turned fifteen and were no longer required to attend. In addition, it was perceived that sometimes it was easier for the school not to report the non-attendance of difficult pupils, or to expel a pupil and pass on the problem to another school, as John found:

For the last two months of school there was, I think there was eight of us just didn't go in so we ended up every day just doing nothing. But I wasn't expelled, I was told, like when I applied for another school the thing they sent on just said that I done me Inter. Cert. [junior examination] and left so, that's how I was able to get into the other schools.

Other students found alternatives to mainstream schooling in more vocationally oriented courses such as the *Youthreach* training programme for 15-17 year olds who had left school without qualifications. However, even though it is the responsibility of the school to refer early leavers to the scheme there is, as McSorely (1994) notes, no effective mechanisms in place to do this. In addition, many of the early leavers are ineligible as the scheme is restricted to those 15 years and over.

Nonetheless, some of the heroin users such as Katie, who left school at fifteen and entered a Youthreach programme which combined academic with vocational subjects, found this a more palatable alternative to school and one which offered a financial incentive and credentials to boot:

I applied down here 'cos I never did a training course. So I went back to school here and all and I passed everything so I was delighted 'cos what I didn't do in school I did here and I got Certs. for it whereas in school you don't unless you go to do your Leaving and Inter [school examinations]. So I got Certs. down here so I was delighted with meself.

But for the majority of those I interviewed, leaving school early with little formal education and no qualifications left them drifting in neighbourhoods with little to do and few opportunities to create a meaningful life.

Early school leaving and unemployment

Early school leaving and a lack of educational qualifications impacts on individual's options and opportunities in the labour market, as noted by the European Social Fund, Policy Evaluation Unit:

"The risk of unemployment and, increasingly, long term unemployment is concentrated amongst those who are most severely educationally disadvantaged." (European Social Fund, 1996, p41)

For example, according to the 1996/7 school leavers survey over 78% of early school leavers entering the job market with no qualifications were unemployed a year later, compared to 48% of Junior Cycle leavers and 28% of those leaving after Senior Cycle (McCoy, Doyle and Williams, 1999). While, Hannan (1992) noted that unemployment rates among those who had left school without any qualification had been almost three times greater than among those who sat their Leaving Certificate examination.

In turn, as early school leaving is concentrated in areas of disadvantage, so too is unemployment. The temporal context in which the young people included in this study left school was pre-'Celtic tiger' Ireland where mass unemployment was the norm in working-class communities. In this context of increased unemployment and the decline of the unskilled employment sector, came increased competition for jobs and the need for a Leaving Certificate as a minimum recruitment qualification.

Few of the interviewees had, at the time of leaving school, realised the connection between early school leaving and employment, and the impact the former would have on the latter. Later on, a number made the connection that education was more than about learning but also a mechanism for future employment prospects, Joni related:

I never understood what school was about until I went into second year. It was second year when I really kind of understood about school and I mean that's pretty late in life do you know, I mean I was after going through the whole of primary school not knowing anything. Like I'd say yeah I'd do me sums I'd do this, I'd do that, but it was only when I was in secondary that I realised like you go to school to get an education and education helps you in your, you know, to be whatever you want to be when you grow up. Like I never wanted to be anything outrageous or anything like I just, I suppose I just wanted to get some sort of a job I mean I'd like, I mean if I sat down to dream about it, I'd like to have a managerial type of job.

Similarly, Jack, who had left school before he was fifteen, was concerned that his daughter have the opportunity to get a 'proper job':

It's desperate, that's why I want to keep my young one in school until she's eighteen 'cos there's nothing for them at fifteen when they get out of school you know what I mean. Like I've a friend that has a [market] stall and he was saying he'd give her a job but that's not a career sure it's not you know.

Others, however, were of the view that your educational performance did little to enhance employment opportunities. As Steve commented:

I know people who went to that school who done their Leaving Cert. who got straight As in their Leaving and are still on the labour [welfare] you know what I mean. People say you're better off learning doing all your education, doing your Leaving Cert. but that doesn't guarantee you anything.

A further contributory factor to the spatial concentrations of unemployment, and one

which helps explain the perception of the meaninglessness of educational qualifications, is that of the 'address effect' (OECD 1998; Corcoran 1998). In this respect, with the collapse of most locally based industries during the recession, job-seekers from disadvantaged working-class neighbourhoods found that they were stigmatised by where they came from when they went to seek work elsewhere.

Employment opportunities

Not only are employment opportunities restricted for those with minimal or no qualifications but the type of employment opportunities open are mainly for manual, low paid, insecure work. As the 1995 School Leavers Survey noted, over half of school leavers who left without qualifications, or with the minimum Junior Certificate, and who found work did so in manual occupations.

Katie's experience was typical of those who found employment; poor pay and poor conditions:

I worked in a restaurant in town when I was fifteen. I worked there for two year. Didn't like it, like 'cos I was only fifteen I was only getting eleven pound for ten hour shifts so I didn't stay. I went on to work in a pressing company and it was piece work and I was there for nearly three year and then I was having the baby so I had to get leave you know and then I never bothered going back. The summer was a killer like you know, working with twelve irons going in one room you know, so I never went back.

Another contributory factor to employment opportunities, especially in the unskilled sector, was the need for contacts with a network of people who were working and could provide an informal source of information about job vacancies. If the young people's own family members and neighbours were out of work, as was the case for Sarah who commented that:

The last time my Da worked was when me eldest sister - she's twenty-five in October - was two.

then the prospect of picking up even casual labour was low. Brian was one of the few interviewees who had been successful in securing work as a result of such contacts:

A: I came out of school and walked straight into a job. The only reason I done that was because it was the same company me Da was working for. Me Da got me the job there. I was working there for two years

you know with me Da and I worked then 'til I was just about eighteen 'til the company closed down.

Q: And what were you working at?

A: Building factories and just loads of work, mainly like labouring work.

For those with drug problems who managed to secure work, holding down a job was difficult, as Kathy described:

A: I left school you know when I was thirteen and I got a job. And I left that. I couldn't hold down a job or school, do you know.

Q: And what job were you working at?

A: I was working in catering. And I couldn't hold it down. I was too sick do you know with the drugs.

Q: And how were you getting away with working when you were thirteen?

A: Because I used to say I was sixteen when I used to work in the catering.

Q: Yeah and they didn't look for [papers]?

A: They didn't look for it, no. I worked in a lot of places when I was thirteen, fourteen and said I was sixteen, but they'd be only for a few days you know, 'cos I wouldn't be able to hold them down.

Q: And was the money any good?

A: No, it was only forty pound and stuff like that you know.

Q: Per week?

A: I never even reached a week in a job to get wages do you know what I mean. I used always just have to go out and rob for me own money you know.

However, Tony managed to keep working for a number of years even with his drug habit:

I was still working, so at least I had that going for me. See, I've no brothers or sisters, do you know what I mean, just me and me Ma, like I just, I couldn't, no matter how bad I was, I couldn't leave the job no matter how bad I was I always went into work. I was thrown home now a few times you know, 'cos I'd be getting sick and all, I'd be in a heap but I'd still, no matter how bad I was like, I still had to keep me job. But I got made redundant, after five years there I was made redundant.

Impact on the neighbourhood

As noted by Whelan (1994a, p145):

"The increasing tendency of those without educational qualifications to be drawn from the lower working class and the increasing risks of unemployment associated with this status ... all contribute to the preservation of class differences in life chances and, in particular, in exposure to poverty."

The dynamic created by all these factors – poor education, unemployment and

poverty - when concentrated in disadvantaged working-class neighbourhoods was seen to create and reinforce the social exclusion of these areas. However, while educational disadvantage may be seen as the main precursor to unemployment; and poverty the main outcome; there are other related issues. Work provides both economic resources as well as giving a structure and meaning to the day, as Brian described:

It was hard, but it was great. You know what I mean. You're out there all day, you come home, go out with the girlfriend and then the weekend you come here and you go to the discos, you've have a few quid in your pocket, that was the main thing you know what I mean.

Once out of school and out of work, the norm, as Samantha described, was that:

Most people didn't do anything, you know. I mean I know a good few people that haven't actually done anything since they left school and that'd be ten years ago.

In such circumstances, the possibility of becoming involved in 'deviant behaviour' is high. As McSorely (1997, p39) noted:

"A young person who is out of school and has an unstructured lifestyle is more likely to become involved in delinquent behaviour."

And in the case of these interviewees, the behaviour they turned to included copious amounts of drug use, as Terry explained:

Q: In an area like Westown, like you were saying people weren't working, what do people do all day if nobody's working if you know what I mean.

A: Nothing, nothing just sit around, don't get me wrong like there's a lot of people do work in Westown, do you know what I mean. But, most youngsters these days now, my age group and lower, they don't work and they're growing up into drugs, that's the way it is.

While few of those who subsequently became heroin users had established drug-using careers while at school, it was in the vacuum of their post school non-working lives that their drug careers took off. As Frank related:

I really got into it after school. I smoked the odd joint but not much. I was sniffing and all at times like that you know, used to check out paint or glue but I wasn't really into it. Basically I left school so I could hang around with the rest of me mates you know the way, going off robbing in the factories and, you know, just acting the bollocks.

Within a year of two of leaving school, with little work and little prospect of future

work, the interviewees who participated in this study had developed heroin problems.

Conclusion

In assessing the heroin users experience and outcome of education, this chapter has identified significantly higher rates of early school leaving among the research participants than the average in their neighbourhoods, even though these latter rates had themselves been higher than average.

Factors relating to home and school environments, behavioural difficulties and drug use were explored. Issues such as participation costs, parental support, feelings of inadequacy and alienation from the school structure and curriculum, disruptive behaviour, and experimental drug use, were all seen to contribute to absenteeism, expulsion and early school leaving. The knock-on effect that poor educational outcomes had on employment opportunities was noted as leading to a situation where both educational disadvantage and unemployment were spatially concentrated in the neighbourhoods, each in turn mutually reinforcing the other.

However, perhaps most notably, the phenomenon of poor educational outcomes and early school leaving was not seen to be related to drug use alone, in fact the large majority of the heroin users did not begin using this drug until they had left school. As a result, in the absence of legitimate opportunity structures heroin use offered the prospect of an alternative career.

Chapter Eight

Home and Family Relationships

Introduction

Previous data analysis chapters examined structural contexts which framed the development of the heroin users drug careers; such as their neighbourhood environments, the local drugs market, and their educational and employment prospects. Overall, these settings proved to be high-risk environments in terms of the lack of opportunities they offered their inhabitants. In this chapter, the context of home and family relationships is examined as a setting that has the potential for providing both risk and protective factors for the development of problematic drug use. Here, the heroin users' experience of home and family life, and their relationships with their parents, partners and children are examined. In addition, the impact of the heroin users' drug use and lifestyle on the family is explored both from their perspective and that of their families.

Family Life

Traditionally, the Irish working-class family is large and, particularly in the inner-city areas where extended families lived close by one another, maintains close relationships with the wider family circle. These family ties are often reinforced by structural factors. For example, public housing developments are concentrated in relatively small areas in the city increasing the likelihood of being housed close to other family members. In addition, in more recent times children tend to stay living in the parental home well into adulthood due to the scarcity of public housing and the high rate of unemployment which mitigates against them moving on to independent lifestyles. For the heroin users, there are even fewer opportunities for moving out from their parental home. As a result, social relationships between the heroin users and their families formed a considerable sphere of influence on the heroin users' lives.

Familial drug problems

One of the starker findings of this study was the extent of drug problems within the

families of the heroin users (see Table 5.18, Appendix 5). Even though this work does not claim to be representative of the heroin using population, the fact that over two-thirds of the heroin users interviewed had another family member, either parent or sibling, with a drugs problem indicates that an exploration of the family dynamic may yield some insight into the phenomenon of neighbourhood drug problems.

The lived experience of both inter and intra generational drug problems, mainly alcohol related in their parents' case, was described in detail in the research participants' accounts of how this phenomenon manifested itself within their families:

Me father had an alcoholic problem, me sister and me eldest brother were on gear but they're off drugs years, they're married with kids. Me other brother is on the [drug treatment] clinic here. Me other brother's a gambler, he doesn't drink or smoke. Me other brother is a twin, his twin died three days before his communion, he's strung out on Napps [morphine sulphate tablets] and he's in bits. So I mean me father's not the only one but me Ma doesn't drink or anything do you know. [Ellen]

I came from a small family, but one of me sisters was on drugs and me brother was on drugs. They were all drug addicts, and me uncle was on drugs and some of me uncles were after dying from AIDS, I grew up around it a lot you know. [Kathy]

I come from a family of heroin abusers, from my mother right down to the youngest of us, except for the baby. My Da's a heroin dealer, he's now doing twenty years down in Portlaoise [prison]. Me 'oul man [father] never used drugs years ago, but then me Ma started taking them, and in the end he got himself strung out as well. So my mother takes drugs, I've a brother HIV positive, I've a sister HIV positive, me other brother took drugs, me other sister takes drugs. They're all in prison now ... there was loads of gear in the house but like they didn't all sit in and smoke around the place or anything like that like, me Ma wouldn't have that. But I did see me brother and sister smoking and banging [injecting] it, do you know what I mean. And I did, when I was very young see me Ma skin-popping it. Like I walked in and I wasn't meant to see it. And I've seen like ounces of heroin on the table ... and like if I went out and picked up gear for me Da or whatever come back, you know he'd be weighing it up in the kitchen away from me nanny and granddad you know what I mean. I'd be sitting there and me Da used to, if he got new gear he'd say 'here, test that'. And I used to be there and I'd be nearly vomiting ... I had a horrible time growing up, it was a really horrible time for me. [Joni]

Growing up in a family home where one or both parents had a drugs problem and

the consequent atmosphere of tension and aggression that filled their home lives was a recurring topic in the heroin users' narratives, as Annette and Kelly described:

My Ma and Da are alcoholics you know, they were always fighting, killing each other. Always drunk they were never sober do you know, really bad alcoholics like they were always there in the house for us and we always got food and clothes and things for Christmas and we always got money and do you know all those things but we never had them like for them do you know what I mean. They used to give us everything but it wasn't, it wasn't enough do you know ... me two younger brothers now they're on drugs, they're sixteen and eighteen ... see me Ma left when he [the youngest] was seven. Me Ma left me Da you know ... he still drinks bottles of whiskey straight every day and he still works, now he's sixty-six, he's a carpenter and he still works every day. He's up six o'clock in the morning goes to work. Comes back with his drink and sits in the house watching telly with his drink. [Annette]

My father was an alcoholic, he was a heavy drinker and a gambler, so from a kind of an early age, I would have been aware of things like, not having enough money, Mum saying, 'Don't eat that 'cos you need that for school tomorrow'. Stuff like that. And there would be a lot of trouble at home, there was a lot going on, there was violence in the home and there was, you know, there was drunken screaming and shouting every night, there was so much trouble in the house that I could slip off out and not come back 'til four or five in the morning, that was, it wasn't okay, but there was so much else going on, that I wasn't reprimanded for it. [Kelly]

Risk literature has identified parental substance use as a factor in the development of problematic drug use, both from a genetic-biological basis as well as through their impact on the quality of family functioning (Health Advisory Service, 2001 p12).

While both these issues may well be contributory factors, they can only offer partial explanations. The question still remains - why are families in whom drug problems are concentrated, in turn concentrated in particular neighbourhoods? Is it the macro or micro environment that is the chicken or the egg?

Family support

Interestingly, despite accounts of the difficulties arising from parental alcohol misuse, the notion that family dysfunction may be even partly attributable to their development of a drug problem was refuted by the heroin users. Rose was adamant that her drug problem had nothing to do with her family background, even though her father had a drugs problem, citing her 'clean' and successful brothers and sisters

as explanations:

No it's not. And you hear people saying about families and all that shit, like my ma done everything for me do you know what I mean. Like it's nothing to do with me Da or nothing do you know what I mean, it was nothing at all to do with them. It was me, what happened to me do you know what I mean, myself. It's nothing to do with your family or anything like that, I hate people saying like that, 'ah well she came from a broken home, what do you expect' and all that shit, it's got nothing to do with that at all. 'Cos most of the parents and everything, I know they haven't got money or anything, but I'll tell you they're fucking great do you know what I mean, like they do everything they can, you don't need money or anything like that. But they do everything they can for us, but it's not they're fault, do you know what I mean so they're not going to be able to stop it. But they do, do their best. Like my Ma is real respectable and all do you know what I mean like, she, none of me other brothers and sisters, they're all grand do you know what I mean. Like one of me brothers are living in Jersey, he's doing great for himself. Me other sister has a lovely house up here, she has a fella and a kid and all, she's grand, even though they're only young, but they're grand do you know what I mean. It's nothing to do with the families at all.

Rose's positive view of families as a source of support was one which occurred frequently in the heroin users' accounts. Initially, though families were ill-equipped to deal with the impact of heroin and had little knowledge of the drug aside from hearing stories about its use in the neighbourhood. Indeed, many of the heroin users had been using for some time before their parents became aware of the situation, as Christine and Caroline related:

When I started off, I started going up to me bedroom, 'cos me Ma hadn't a clue, and it was great you know being in the comfort and it was warm and I used to have loads of people all sitting up in me bedroom 'cos me ma never thought in her wildest dreams, do you know what I mean. So then she started finding you know, bags of sick around the house and you know some burnt bits of tin foil and all that. So she started questioning me about it and I was saying 'no way' and starting fights with her ... and she'd be crying and she'd be running everywhere trying to get me help. Ringing up places and she'd be saying to me 'please don't do this', and I'd be saying 'ah shut up you' and, you know, causing a big fight. [Christine]

It was my daughter that actually told him [Caroline's father]. She was after coming up to the bedroom and she caught me with the tin foil in my hand smoking it. And as I said she's very, very cute. Like she's five, but she has the brain of a ten year old, do you know what I mean. So she seen me smoking and I think it was a couple of days later, my Da was getting ready for work and she was up for school, and then he was

doing his sandwiches for his lunch and he started wrapping his sandwiches then into his, into the tin foil. And my daughter said, 'Granddad you don't do that, you don't put your sandwiches in tin foil. You smoke that the way me mammy smokes it'. So he ran up to the bedroom and there was murder then. [Caroline]

After the initial anger and shock, many parents rallied around and found themselves on a rapid upward learning curve about drug problems and the services available. Many parents, usually the heroin users' mothers, joined family support groups, which had been established by community organisations and Narcotic Anonymous type groups in many of the heroin neighbourhoods in the city. Through my ethnographic work in Eastown, I was invited to sit-in on community run family support meetings to hear their stories and their self-help strategies developed in the absence of formal responses from the statutory services. As Connie, one of the mothers, related

When we started going to the meetings then, the talks, the counselling. It made us realise that we have a voice ourselves and we have a life so we have to get on with it. So we did and I think they helped us a lot as well you know.

One of the main difficulties at this time was the absence of drug treatment services (see Chapter Nine), as a result families assisted the heroin users in seeking treatment and paying for this. Tom's mother and grandmother, with whom he lived, helped him to find a GP who would prescribe methadone to him and paid for this treatment, after he went to them for help:

I just showed her one day, showed her a needle, showed her me arms 'Nanny I'm strung out' she didn't even know what heroin was, hash that's all she knew, in her days it was glue sniffing, so she hadn't got a clue about it, so I just said I wanted help, Ma brought me around to a Doctor, took nearly two months looking for a doctor, and when I finally got one, me Nanny paid for it for a while.

Other families organised a home detoxification with help from the family support groups. If a GP could not be found to provide the detoxification, many mothers set about buying the drug on the street, as Steve related:

I tried to do a detox. in the house. Me Ma and I went down to the chemist in Southtown and I stood out there for nearly four hours. Everyone that was walking round we'd ask, 'have you any Phy for sale'. 'I've only two hundred', 'give us it'. Then I'd wait for the next person, buy fifty off him, then a hundred off another until I had nearly two thousand mls and then I'd go home with it and I'd sit in me house, and for three weeks I sat in me house taking Phy everyday.

The impact on families

Overtime though, as one detoxification followed another and the drug free aftermath continued to be short-lived, relationships between the drug user and their parents deteriorated as their drug use impacted more and more on their families' lives. From the families' perspective, the impact on their lives was devastating, as Katie, whose sister developed a heroin problem, related:

It's horrible like. I was nine and a half stone, I went down to eight for me sister. Me Ma went down to six stone and she was fourteen stone. And then out of the whole house, everybody is cranky the whole time, there's never a happy moment. Like our house, we had a real happy house you know like everybody was happy, never any arguments, and then ever since the drugs started you can't even look crooked at somebody now and there's a fight in the house. It never leaves you. It never leaves you, like even, you lose contact with your friends and all. Like we came from a great family you know. We were always well looked after. Me Ma, Ma never went outside the door, never went to the pub, she was always there for us twenty four hours a day. So was me Da you know so, it does make you wonder. Like a great family and a great life you know, always going on holidays and all but that's all stopped. You don't care anymore, like my Ma just, she got to the stage where she wouldn't even walk out of the house, wouldn't even clean the house. That's how bad it just went. We didn't care whether the windows was dirty, nothing. It was just, that was it, we'd no interest.

Indeed, many of the heroin users related how they took advantage of their family's support so as they would get money to purchase their drugs, as Sarah described:

I used to play it for me Ma 'cos I used to know I'd get money out of it and I used to be real, 'I'm dying sick, I'm dying sick'.

Manipulating family members as a means of accessing money for drugs was a common tactic among the heroin users, as Sinead related:

I remember going home, this is where it really started getting heavy, and thinking for ages like what would happen if I told me Ma I owed seventy pound for drugs? And I didn't really owe money, but it was the way of getting you know, that I'd get seventy pound. And I'd worry her sick and she'd give it to me 'cos she'd be worried about me. So I schemed up a plan at home and I said to her, I owe some fella money for some hash and drink and I need to give it to him you know he'll kill me if I don't have it. I frightened the life out of her but I knew I was doing this, I knew I'd get the money. So I got the seventy pound. From then on, I was doing it every week, telling her I owed people twenty pound and I'd be making her feel afraid and I'd be intimidating her so she'd give me the money ... like I was sixteen and I was heavily into

Hash, LSD, and tablets - Roche [Valium], Rohypnol, purple hearts [barbiturates] and drink, Actifed [linctus], gas, thinners, all stuff like that. Me family were worried sick. I used to say to me Ma like I'll be home, nine, ten o'clock and I'd come home at twelve or two in the morning and she'd be sitting up all night worried sick about me. I remember I went home one day I told me Ma that - and it was like, if I tell her I'm on heroin, this will be the biggest one you know. And it was never to tell her to get help. It was to tell her to get the money. And I told her that I was on heroin. I was getting eighty or a hundred pound a day off her. And she was in debt up to her eyeballs with the bank, borrowing money for me and like that's not including what I stole, ornaments and stuff she got. Jewellery that her granny gave her that I took when I was sick and I'd take it and I'd sell it. Go out on the street and I'd sell it and me brother's clothes, all me brothers stuff. I remember one day walking down the road with a top on me and someone said I'll give you five pound and I took the top off me on the road and I said there. And it's like apart from the money, what I did to her as a person, do you know what I mean. 'Cos she aged, she must have aged about twenty years, she didn't sleep for about a year. Like she slept on and off, but she didn't eat, she didn't sleep, she was worried sick all the time you know. She hadn't got money to buy messages [food etc.] in the house 'cos I was out using it. She used to be crying in me face, she'd say, 'you're killing yourself'.

Most of the heroin users also described how they stole goods and money off their family in order to buy their drugs, as Paul and Simon related:

I weren't getting any income off the labour so I found it hard to keep me habit, I'd wake up sick in the morning wouldn't have the energy to get up, get out, try get money I'd just go to me Ma's purse or one of me sisters' and take the money and go off and score, get myself together, then go off robbing and I'd always say to myself I'll put the money back in when I get a few bob but I never did, that's when all the trouble started in the house, when I just kept on robbing. [Paul]

But then like I started getting worse. Started robbing me own, me own mother and father. You know me Ma's pass card, knew the number you know, they trusted me ... like I knew the number and then I'd take the pass card and I'd just take all the money that they had, you know, me Da's money that he got you know and he was fucking out of the job and like I was taking that money, and then the jewellery. [Simon]

In addition to the stealing, parents and siblings recounted the tension and anxiety of finding the heroin user 'out of it', often with a lit cigarette in their hand/lips or unconscious with needle still in situ. The heroin users also recounted how their families had to deal with their erratic behaviour when under the influence of drugs. As Sarah described:

If I wasn't out of my face, I was out looking for stuff, you know or I was sick, like there was times where she [mother] had to bring me up and put me into the bed, I'd be that out of my face like, I'd fall in the door and my little brothers have seen me like that you know.

Many parents related stories of how they sought to control the impact on their family by locking away their own possessions and taking locks off doors to hamper the heroin users from using in the house. Brian related his experience of this as his mother sought, in vain, to minimise the impact of his, and his two brothers', use on the home:

Me Ma had to break the door into the kitchen and of the bathroom, the toilet, the sitting room and the bedroom so we couldn't be doing anything. I've put more fucking locks on that bedroom. She took them all off. Smashed the fucking bedroom up over it. Like she was saying, 'this is my house, you're not doing this, you can go outside. I don't give a fuck what you do outside. But you're not to do it in my house.' Like you walk around here and you see posters in people's windows - 'We want a drug free zone'. And my Ma hasn't got one in her window, she has it in the house you know, at the back door facing the house, and me Ma says 'I want this house clean, no drugs at all taken in this house'.

Becoming homeless

As the heroin users' drug use continued unabated and the friction and arguments continued, many of the heroin users would start moving back and forth from their parental home to a 'free gaff' [house], disappearing for days at a time so they could freely indulge in their heroin habit even though conditions where they were staying were poor. As Kathy described:

I used to stay out of me house all the time you know. Sleep around in cars and house sheds and things like that. Sleep anywhere do you know. I was never in me Ma's, I was always in someone else's house it was horrible it was you know but at that time I didn't care as long as I had me drugs.

Many, though, were asked to leave their parental home by parents who were influenced by the 'tough love' ethos advocated by the NA family support groups, as Annie experienced when her parents asked her to leave and she ended up homeless sleeping in a friend's garden shed:

They kicked me out there last September and I was out from September 'til about the start of December. I took money again and they kicked me out. And when they kicked me out I was living in a shed in me mate's back garden. Her Ma didn't want me in the house, she knew I was on

drugs like, but the Da was real nice, sometimes he used to sneak me in and I used to sleep on the couch and they used to wake me before the Ma used to wake up so I'd get back out to the shed.

Overall, many of the heroin users experienced periods of sleeping rough as homeless hostels were reluctant to accept active drug users. Joni ended up on the streets for "six days and six nights through the Christmas". Others such as Charlie, slept rough for some time and then managed to access a hostel for some of this period. However, hostels only provided minimum accommodation and drug use tended to become more problematic during this period:

I was a year on the streets and it's horrible. You get kicked out of the hostel at what, nine o'clock in the morning, and you go back at six o'clock at night. And I'd nothing to do but walk around town even when you're sick like with flus and migraines, and you've nowhere to go or anything. You can't even go down and relax you know. It is horrible. That's why they end up bad on the gear you know. That's why people take it.

And for the female heroin users sleeping rough on the streets, there was the additional risk of being attacked, as Tricia described:

It almost happened to me only for I knew the person you know I nearly died. And it happened to a couple of me friends as well, and a couple of other girls I knew. It's like when you're out of your gaff and someone offers you somewhere to stay you're going to grab it. You're going to take them up on it you know what I mean. And then if that happens to be a young fella, and you think you could trust that young fella you know, 'cos he's nice and I've somewhere to stay and you go to their house and then there's his hands all over you and what can a girl do against him, not much, and the girl's strung out to bits like that she's weaker the girl you know. It's bad enough being homeless without all that crap, you know what I mean, if there's a crack house, as we call it, around you'd do alright, you'd just stay there you know. But if there's not, you could end up staying in the park you know what I mean or someone's shed.

In some areas, such as Northtown, Southtown and Talltown, empty flats regularly turned up in the flat complexes and were quickly seized by the heroin users, as Annette described:

I squatted in loads of flats, seven or eight of them, someone would say to me such a person is moving out of a flat and I'd move into it. Whenever I got fed up in me Ma's I'd move into it and then I'd move back out into me Ma's and then I'd move out again, back and forward all the time.

Some of the heroin users, mostly women, who had their own home, allowed others to use their house as a 'free gaff' and often in return would be given, or invited to share, some of their guests' drugs:

If someone came up and says to me 'can I have a turn on Joni, I'm dying sick' or something like that do you know what I mean, well I'd say, 'go on into the bathroom clean up after you and then go out', do you know that way. 'Cos it wouldn't bother me do you know. [Joni]

I let the flat really go to bits 'cos it was like junkies paradise. 'Cos we used to just all sit around and we'd be all like this out of our faces and everything. [Sarah]

However, the female heroin users also recounted stories of being intimidated into allowing their home be used by the male drug users in the area, as Frank admitted to doing:

I always found a free gaff to stay in you know like there'd be some bleedin' unmarried mother or someone would lose control of her gaff to you, let you in and that'd be it you know, take over her gaff. Just mess in her gaff, sleep in her gaff. That was it. Go robbing every night from her gaff, just use her gaff you know. Just seemed to be always someone there to let you do that you know.

This situation placed the female drug users at an additional risk of losing their home as, during the fieldwork for this research there was a high level of activity by community activists and local authority housing departments to control anti-social behaviour on the estates. And, as a result, a number of the heroin users were put under pressure to vacate their homes, as Alice described:

I was in Mountjoy [prison] at the time and there was people getting in the window and they caught them and when I got out, me hall door was gone from them booting it in, so now when I was sick I got on the phone and said get the flat barred up until I get out. Got out of Mountjoy, went out to get me flat opened back up but they wouldn't do it.

Relationships with Partners

Given the difficulties the heroin users were experiencing in their familial relationships over the use of their drugs, it is perhaps not surprising that the personal relationships they formed were most often with other heroin users, as Lucy remarked:

I think an awful lot of people that are together when they're on drugs is

only together because they're on drugs, one might have the money now, the other might get the money later on, that's the way it goes.

However, among the heroin users interviewed for this study, it was noticeable that far more females, indeed nearly all, had drug-using partners (90%) as opposed to their male counterparts (57%) (see Table 5.17, Appendix 5).

Many of the female heroin users had been introduced to the drug by their partner, as Jessie related:

Straight away I loved it, I think I loved it more because at the time me fella was doing it so I wanted to do it as well but then eventually you just get a taste for it.

The women's romanticised view of this shared experience was sharply contrasted by the male drug users who related more practical motives such as encouraging their female partners to use the drug in order to make life easier for them, as Tom described:

She was moaning at me when I got on it, so what I done to shut her up was to get her to smoke it so she couldn't fucking nag at me then the two of us just got strung out.

In contrast, to the women - who had less time and space in their lives, mainly due to having children - the male heroin users had greater scope to carve out private spaces in their lives and, consequently, be able to hide their drug use from a non- drug-using partner, as Anthony described:

She knew that I smoked hash and that when I first started going with her. And if she came in and me eyes would be pinned or whatever she'd say 'Jaysus you must have smoked a lot of hash' and I'd said 'Yeah, I smoked loads'. That's the excuse I used to use. Instead of saying, 'No, I'm after being smoking gear today'. I mean she didn't know I was strung out for a good while either you know. And then even when I started using needles, it was a good time a good few months before she realised I was using needles 'cos I was banging into my feet and all, know what I mean, so there was no track marks on me arm and all, and if there were track marks on me arm I'd make sure the lights would be out before we were going to bed so that she wouldn't notice anything.

The sharing of drugs between partners was often accompanied by the sharing of injecting equipment, a phenomenon that was perceived as safe as long as it was with your partner, as Tom also described:

I only ever shared a needle with me bird that was it ... that was all the one 'cause I was sleeping with her anyway, like you know what I mean,

so it was all the one if you're using the same needle, anyone else now never, never took the risk, wouldn't have it.

Indeed, despite the high level of HIV and Hepatitis C among the injecting drug-using population in Dublin, the heroin users were not deterred from unsafe sex or injecting practices. Indeed, Charlie was one of the few people interviewed who was vigilant of his sexual health, and consequently found it difficult to form relationships:

I haven't been with a bird [woman] in over, about two years and I could have been, but I don't want to put meself at risk 'cos they're on gear, you know, and I don't want to take a chance of having sex with a bird and she's full of the virus [HIV] or whatever. 'Cos I'm not saying I'm squeaky clean but I protect meself having sex and specially like there's no way I'd go near birds that's on gear and every bird that I know is on gear.

While the heroin users themselves did not appear concerned about contracting HIV, this was one of the main concerns of their families. Many of the female heroin users related stories of the anger and hostility shown to their drug-using partners by their families, particularly when their partner had been the person to introduce them to heroin, and also where the care and welfare of the heroin users' children was an issue, as Sarah related:

I'll never forget it, Da head butted him to the face, and me Ma said 'I blame it on youse, you have her on this needle' and everything else. And me Da of course with a few drinks on him starts, you know being the hard man, 'I'm going to fucking kill him', he starts saying. 'I'll throw you over the balcony' and all this ... And I was there, 'It's not his fault, it's mine', I said, 'it's your own decision' ... I mean my Ma doesn't really get on with my fella because of drugs like, she thinks he doesn't do enough for the kids or anything like that, but like he does, like she doesn't like know, like he probably wouldn't give me money for the kids but he looked after my habit for so many years you know.

Non-drug-using partners were similarly concerned about catching 'the virus' and these relationships were seen to flounder in the long run, as Anthony related:

When I first started detoxing, I didn't want to, it was just for me girlfriends sake. I used to be saying that I'd give it up and then I'd do a detox, but I'd be still taking it on the sly banging into my feet and all where she wouldn't see the track marks. And then she'd find out that I'd been there back on it or else I'd tell her when I'd be strung out. And eventually she just finished it with me. I can't blame her, know what I mean. But she was right finishing with me 'cos her head was wrecked having to worry about me all the time and then when I started getting locked up and all, having to visit me in prisons, and worrying that some day like I'm gonna OD, or that I'm gonna catch AIDS off using someone

else's works and give it to her. I probably wouldn't have put up with it you know. It's over two, two and a half years ago you know. That was me last real relationship with feeling, know what I mean, any girl I've been with since then have been all drug addicts.

Where both partners were heroin users, relationships were also put under strain when one partner wished to give up using the drug, some reaching the point where they had to leave their heroin-using partner in order to leave the drug behind, as Joni described:

I mean, you can't do it. There's no way that two people can live together and one of them try and get off gear and the other one not. You have to either break up or try together do you know what I mean and do it together. I mean it's too hard ... like he was coming in stoned and sleeping on my shoulder and I was sitting there starting to get a bump and I'm worrying about the future, the baby coming along. How are we going to live, how we'll get money for this, that and the other and he didn't give a shit. So after three weeks, he wrecked me head so much that I just said, fuck it, and I went on a mad frenzy of taking Rohypnol for about a week and then I said leave Joni, just get away from him. So I got away from him and that was it because I mean, I had a baby to worry about and he wasn't worrying about it. I felt guilty enough after being taking the gear for the first three months while I hadn't got on the [drug treatment] clinic. But now I was after getting a chance and I'd the responsibility of a baby he didn't, so that's how I got away from him.

The impact on children

The heroin users' relationships with their children were often strained and distressed as a result of their heroin use and the frequently volatile nature of the relationships between themselves and their partners. Over half (58%) of the female heroin users and over a third (38%) of the males had children (see Table 5.16, Appendix 5). None of the male heroin users lived with their children and had varying degrees of contact with them and their mothers. In the case of the female heroin users, many of their children lived with their grandparents, an arrangement that for the most part was worked out on a voluntary basis as usually there was little opposition from the women who found their drug use and its accompanying lifestyle incompatible with parenting, as Annette related:

I was living with me Ma and I was after putting in for a flat like, so then when I got the flat like I went, I didn't want to take Keith [her son] with me because I knew, I knew what he was going to be seeing and me Ma wouldn't let me take him here. She says you're not bringing him because I know that you wouldn't mean it yourself to let him see but it would just happen you know and you can't be doing that to him. [Annette]

Others described how they arranged to leave their children with relations so as to shield them from the volatile and often violent way of life that accompanied problem drug use:

The two girls are with their nanny at the moment and my sister has me son. After me husband died, me sister ended up taking the young fella and I got me mother-in-law to take the two girls. Like, he never hit me in front of the kids, but they seen me with black eyes and broken ribs, the whole lot. They knew there was something going on, but they didn't know exactly what it was. They knew he was hitting me and that he wasn't on drugs and I was, but he was a drinker. [Alice]

Like I used to bring my young one over to me Ma because I wasn't into dressing her up, hadn't got the patience. I wanted to just go out and kind of get my drugs. Hadn't got the patience to be giving her breakfast or to dress her and I was kind of 'Ma you're going to have to take her for a while 'cos I just hadn't got the patience for her'. And I was roaring at her and I was picking on her like I wasn't hitting her or anything I used to just roar at her and I think that was worse for her 'cos she used to like kind of get more panicky at me then and frightened then when I'd roar at her. She'd be, 'Ma don't be roaring at me, don't roar at me, I didn't do anything', like I'd feel guilty then and that would make me even more freaked out ... But like, she never got hit, I never hit her or anything like, I was never into like hitting or anything. Like I I'd often say 'I'll fucking kill you' or something and I'd put my fist up to her or something and she'd kind of pull away from me. But like I'd never actually hit her you know what I mean. [Kelly]

For the female heroin users who had neither family, community or statutory support to call on, their accounts and acknowledgement of the impact their way of life had on their children was the most distressing aspect of this study:

Like now my little young one now is going on four years old and if I was going out scoring, she'd start screaming, 'don't buy it, don't buy it, don't buy it', almost like she knew what it was like, I never actually thought she knew what I was doing like once she used to see the little bag, she'd cop on straight away what it was and she'd be 'No', I used to have to stop bringing her down with me because like she used to get very frustrated and she'd start screaming crying and everything you know like. Like she used to, when I'd be in the bathroom, and she'd be saying, 'Ma I want to go in the bathroom' and she'd know then when I wouldn't let her in the bathroom, she'd know and she'd be saying 'Mammy don't be doing that, don't be doing that, that's dirty', you know what I mean. [Kathy]

Like I always made sure that their food was there for them and I always made sure I gave them plenty of love, then other times when I was sick, I'd be narky with them. I'd probably snap at them and like they'd look at me and I think they knew I was sick but they didn't know from what,

they'd just come down here to me and I'd ask one of them to go and get me medicine and like if I was standing outside all I'd get is 'come on Ma, are you coming, are you coming' and the young one said to me one day, 'I'm not standing down here with you' she said 'cos you're going to get your tablets', like that. The way the child knew and she's never seen me taking tablets or anything like that. But she must have seen them being slipped to me once 'cos she knew. [Maisie]

The lack of support for the families of drug users in the neighbourhoods left them isolated in their predicament, with the children often the main victims. It is sadly ironic how the relationships the heroin users had with their children often mirrored the relationships they had with their own drug-using parents. The impact of this life on the children's emotional and physical well-being poses uncomfortable questions as to their welfare. Without substantial support it is difficult to see how this young generation can survive unscathed the high-risk environment they were born into.

Conclusion

This chapter has examined the heroin users' lived experience of family life and relationships. The concentration of drug problems both within and between generations of the same families is significant and reflects the concentration of drug problems in the neighbourhoods in which they live. This clustering of families with multiple drug problems in the same neighbourhoods, magnifies the difficulties for the individual, their family, and community and leaves many parents, siblings, and especially children, living in the most difficult of situations. Indeed, with the next generation in the neighbourhoods growing up in an environment where drugs affected both their family and community life, it is difficult to see how they could avoid the consequences of the multiple risks which surround them.

In the following final data chapter, the options available to the heroin users who wished to curtail their drug careers will be examined.

Chapter Nine

Giving up and moving on

Introduction

In the heroin users' descriptions of the process whereby their drug-using career developed, the soothing properties of the drug and the 'buzz' in terms of the accompanying lifestyle and status were noted as being among its main attractions. Over time, however, these attractions were increasingly counteracted by the raft of difficulties they experienced as a result of their continued drug use. For many, these difficulties became turning points in their drug-using career and led the heroin users to reconsider their lifestyle and to attempt to control and/or give up using the drug.

This chapter maps out the issues which the heroin users identified as key turning points in their drug-using career and describes the factors which facilitated and/or hindered their attempts to stop using the drug.

While I have categorised the recurring themes of transition individually, it is worth noting that these often overlapped and that the heroin users most often experienced a number of turning points simultaneously which prompted them to reassess their drug-using career.

Transitions

Controlling 'the sickness'

In Chapter Five, the heroin users described the onset of 'the sickness' - the withdrawal symptoms experienced when the effects of the drug began to wear off and the craving for more began – as one of the significant points in their drug career. Over time, coping with the sickness and the frustration of trying to duplicate the initial buzz that the drug had produced, led many of the users to adopt strategies to control or cease their heroin use. For example, Caroline tried to move away from injecting back to smoking, as she perceived the sickness had been less severe when she had been smoking heroin:

Bit by bit then I started getting more addicted to it ... I started using,

injecting it. Then I stopped using it and I went back to smoking. I stopped first, went through cold turkey for four days, you know so I'd be able to stop using ... then, I went back to smoking it to get something out of it, I just wasn't getting anything out of it anymore, it was just stopping my pain and that was it.

Inevitably, though, the heroin users reached a point where giving up the drug seemed the only solution. As Sean related:

I mean I've had a problem for years and then just there, just before Christmas [one month before the interview], I decided I just can't go on living like this anymore you know, every day was becoming a major struggle, I wasn't even getting stoned anymore, it was just like sort of you were surviving and avoiding sickness each day and I just woke up one morning and said I've had enough. This has got to stop.

The effect on appearance and health

Another turning point in the heroin users' career was the effect on their general well being. Many, especially those who were experiencing bouts of homelessness and nights on the streets, ended up in a dishevelled state selling off their clothes to pay for their drugs. For some users, this decline prompted a desire to turn their life around. As Pat explained:

I'm sick of it, really sick of it. I'm twenty eight now, I don't want to end up being a bum you know, going round with bleeding shoe laces holding up me jeans, living on the streets. No way, it's not for me. I made a mistake but I have to get off it and I'm going to. I can. I will. I'll do it. I really will do it.

The impact on the heroin users' health was also severe. Those who were 'chasing' the drug were prone to respiratory illnesses while those who were injecting often suffered abscesses on their injecting sites. In addition, there was the added risk, and sometimes reality, of becoming positive for HIV, and/or Hepatitis B and C. As Joni and Maria described:

You're that sick, of putting needles into yourself, you'd have your arms in bits, you'd have no veins anymore you're bruised to bits you know what I mean, and you'd be fucking saying 'Oh Jesus, not again', it just sickens you after a while like it does. [Joni]

I started spitting up blood and going into hospitals, couldn't breathe me lungs were clogging up, collapsing. My body's all disfigured from it. And it's mostly what made me give it up do you know, 'cos it's so painful sitting there with a needle inside you. And I wasn't getting anything out of it, I was only getting me head fucking straight together. [Maria]

Experiences of overdoses also led the heroin users to reflect on what they were doing and seek help, as Kathy related:

I was enjoying it for ages you know. Then I started overdosing and all do you know what I mean and I just wanted to die, stuff like that. It was like days that I'd no drugs, I wanted to kill meself and die you know. Somedays being fed up with your life do you know and then times that I'd say ... I want help, I'd be fed up. I was on drugs for a long time. I was on gear for just three years before I seeked help. Yeah, it was long enough you know for me.

Lifestyle fatigue

The attraction of the junkie lifestyle which initially gave a meaning and a purpose to the heroin users' daily life began to fade for many as the never ending cycle of finding money, scoring, and using, became increasingly burdensome. As David described:

I just got sick of that. Waking up every day and having to find this and do that and tell this person this and lie about that, and get a lend off someone and dodge a person I got a lend off the day before and all. Just got sick of the whole life of it.

Damien too recounted how he was:

Fed up being on drugs all the time. Just running around robbing and all, you know what I mean, getting in trouble, getting locked up, getting out, robbing again, going back in you know. So, I just want to get me head together now and settle down for a while.

For others, such as Maisie, the realisation of how their drug use was impacting on their daily lives prompted a desire for change and a more 'normal' way of life:

I was getting fed up with having to get up in the morning and go out robbing, then you have to go and sell it. Then, when you get the money for selling whatever you're after robbing, you have to go and look for the gear and get that, and then you're trying to look after kids and keep the house clean and do everything all at the same time and I just got fed up with it, so I said I'll have to get help ... I want to get off everything. I want to get a job, I want to get a comfortable home together, I want to get out of my financial difficulties, I want to get all me court cases cleared up and I want to be normal again. To be able to wake up some morning and just be a normal person again.

Rory too shared this desire to be 'normal':

I think that part of why you want to come off drugs is because you're realising that society around you doesn't accept you being mad out of your face all the time you know. And if you wanted to fit in and live

normally and go for drinks on Sunday and go to the park on Saturday with your mot [girlfriend] you know, things like that, you have to stop taking drugs because your whole life just revolves around drugs. You get up in the morning you go out, you get your fix and come home and that's your day finished you know, and have a psychedelic evening why don't you because the next evening you're going to do it all over again, you know.

Meeting the ongoing financial burden of a heroin habit was another downside of the lifestyle, as Des found:

It leaves you with nothing, you have no money or nothing like. I'd sold all me clothes you know what I mean. And then, I just couldn't do it anymore, 'cos I'd fuck all left. I'd nothing.

For Annette the expense of her heroin habit took its toll in terms of the extremes she had to go through to finance her drug use:

The last four years was the worst for me though. God I was really just, I'd nothing do you know what I mean. I'd lost - me kids were taken off me and everything you know. Me four kids were taken off me and I lost me flat. Before I lost me flat I'd no electricity and no money and what money I had I spent on drugs you know. I didn't care I was in an awful way going round. Then, I was prostituting and all for money you know, you'd do anything for money. I used to do that when I couldn't get into any shops anymore in town you know 'cos I was stealing. I was barred from all the shops and so I had to go out prostituting you know to get the money. The only way I could get the money was to do that you know. So just one day I just realised I had to come off drugs you know what I mean.

Joni related how even though she still liked taking the drug, the continuous lack of money was part of her reason for giving it up:

I never wanted to stop taking gear, do you know what I mean, the only thing was I hadn't got the money to keep the habit going do you know what I mean like. Like other than that like, I liked me gear, I enjoyed me gear and I wouldn't have stopped like only that it just got too much. Me habit was too much and I was, really, just barely surviving like.

Indeed, it was rarely the drug itself that caused the problem but the accompanying lifestyle brought about by not being able to afford the drug, as Frank, remarked:

Nearly everybody wants to give it up when things are hard. When you've plenty of money there's nothing wrong with you - it's not a problem when you have loads of money.

Contact with the criminal justice system

Another significant turning point in the heroin users' drug career occurred when they fell foul of the criminal justice system, which, as described in Chapter Six, seemed to become inevitable over time.

Many users preparing for upcoming charges and court appearances, often elected, or were advised, to prove they were willing to enter treatment and/or have urinalysis to demonstrate that they were no longer using heroin, so as to mitigate their charges or avoid a prison sentence, as was the case with Caroline:

I'm in court now on the 20th of this month for sentence like because of the drugs and I know that I have to have clean urines and I have to be clean off drugs or else I'll get 18 months in prison.

For other users who were involved in dealing in their neighbourhoods, the stress of coming under constant surveillance by the police and/or community activists, prompted the desire for a change in lifestyle. As Steve recounted:

The police kept me under surveillance for two weeks, they followed me around, I had to move to X [another neighbourhood] with me auntie and they still came out there after me. So I said right I'll leave it for a couple of weeks. Left it for a couple of weeks, came back to Westown and they just done the same thing over again 'til I got so bad and that it made me say - Stop I have to get off this drug. I was down to seven and a half stone I was half done. I mean losing friends from drugs you know what I mean taking overdoses and that, and more fights with your family and doing stupid things, so I says, that's it, I'll knock it on the head do you know what I mean, bump.

Others were prompted to change by the fear of being committed to or returning to prison. Sean had been in prison in Australia and his desire to avoid repeating the experience was one of the many reasons he sought treatment for his problematic use of heroin:

I only got a three months prison sentence and I did that and came home then to Ireland and then used for about a year afterwards and then came in here [drug treatment clinic] after that. Because I knew if I just kept on using I was going to end up back in jail again here and I didn't want that to happen. Just jail here isn't healthy for anybody.

However, for some of those who were committed to prison this provided an opportunity to stop using drugs, albeit if shortlived, as Tom, who was in prison at the time of the interview, related:

I was in a bad way coming in here, very bad way, I'm kinda glad I got locked up 'cos I needed time to think and get off drugs and get me head together, the feeling of waking up in the morning and not being sick was great.

Family

Support and/or pressure from the heroin users' families also led the users to consider giving up the drug, particularly when they realised the impact their behaviour, such as stealing from their families to finance their drug habit, was having, as Charlie related:

Robbing me family was the lowest thing I've ever done so I said I have to do something about this - that's why I was saying I have to get on a clinic - that was the lowest thing I done.

For many of the women interviewed, pregnancy and child-care responsibilities marked a turning point in their heroin careers and prompted a desire to give up the drug and/or go into treatment:

Mainly what made me give it up, I was after getting pregnant and I was afraid. I didn't want to endanger the baby. [Joni]

I think what really snapped me out of it this time was when I seen the baby going through the withdrawals, that's what frightened me. 'Cos she was so small, do you know that sort of way, she was early, she was four weeks early born. [Sarah]

I think what made me get help first was for me baby's sake it wasn't for meself like I wasn't seeing her at the time 'cos I couldn't go in and out 'cos me days were taken up with trying to get money and all and when I was sick, when you're sick from heroin you can't have kids around you, you know its hard to try and listen to them, have time for them when all you're thinking about is heroin d'you know and then when you're stoned you - it's only when you get something and you're alright that it makes you think d'you know what I mean, like the first time I done it was really for the baby. [Lucille]

But, it was not just the women heroin users whose children and family provided a reason to give up, for some of the men this too provided an incentive, as Peter and Jack related:

I mean I'm trying to get on with my life, I've a kid and a girlfriend and all like so I'm trying to get myself a good job and trying to get off drugs and, like I'd be looking to the future. [Peter]

Chrissie [his wife] was pregnant, so the young one sort of turned me life around for me, you know. It was just when the baby came on the scene I didn't want her following in our footsteps. You know the way they say kids follow in their parent's footsteps. [Jack]

However, attempts to give up heroin for their children's sake were not always voluntary, an element of pressure was often involved from family and/or statutory agencies who warned that their child(ren) would be taken from them if they didn't give up using drugs and seek treatment, as Kieran recounted:

I'm after losing me three kids through drugs d'you know, like her family, I didn't actually lose them, her family has custody, there was an agreement meself and me partner made, d'you know what I mean, that we'd either give up our kids to her family, let the social workers and social services see that her family take the kids, it's like letting them know that we really want help, d'you know what I mean, so that was the real reason we got the help 'cos we gave our kids up. They're eight, four and a half, and three and a half, and I didn't want to come back out of prison with a habit again I wanted to get out clean for me girl's child 'cos I mean she was only a baby when I went in ... I'm really doing it because I want to do it for us to get the kids back, you see that's the conditions, I have to be off drugs long term before I get the kids back, I have to be clean plus I have to have a house, me own house for about six months 'til I get custody of the kids, we have a chance to prove ourselves to get our kids back, our kids deserve more than this do you know, they didn't ask for this, they deserve more, they deserve to have parents that's there for them all the time.

Reductions in supply

The final theme noted in the heroin users' narratives as a reason for wishing to give up the drug was its erratic availability. While heroin 'droughts' are periodically caused by blips in the international heroin trade or successful supply reduction measures by the police and/or customs officers, a particular context of this research was the impact of the murder of the crime journalist Veronica Guerin on the drugs trade in Dublin. In the aftermath of her death a raft of criminal justice legislation was introduced to crackdown on drug dealing resulting in many of the main dealers being arrested or leaving the country. As a result, the users were left without supplies and the city experienced a severe heroin drought in the summer of 1996 (as the fieldwork for this research was underway).

As availability within a neighbourhood was seen to facilitate the development of a drug career, the converse, the curtailment of supplies was seen to lead to a huge

increase in the demand for treatment at this time, as Jimmy described:

I remember it well 'cos I remember there was a queue from Trinity Court [treatment centre] right down, past Pearse Street station you know. Yeah, there was a queue of people because they cleared up town overnight really, the big dealers, and there was a queue going oh Jesus the length of it. All trying to get into Trinity Court 'cos there was no heroin.

Overall then, the main transition points for moving on identified by the heroin users were: recurring experiences of 'the sickness'; poor health; lifestyle dissatisfaction; legal difficulties; impact on the family; and erratic availability. However, there is no certainty that having reached one or many transition points in their career that the heroin users would then successfully end their drug use. The following section describes the difficulties experienced by them in realising their desire for change.

The difficulties of giving up

Sourcing treatment

For the vast majority of the heroin users, discontinuing their heroin use required some form of treatment support¹⁵. However, heroin users experienced enormous difficulty in accessing services due to treatment demand far exceeding supply - at this time there were an estimated 2,000 methadone treatment places (Eastern Health Board, 1997) for an estimated 14,000 heroin users (Comiskey, 1998). As one of the heroin users (Brian) estimated, there were 1,000 heroin users in his neighbourhood in Westown yet the local treatment clinic only had capacity for 15 clients.

Due to the severe under-capacity in treatment services, the heroin users had to wait for some time before a place became available, as Frankie and Kieran described:

You could wait 12 or 6 months, but you want something straight away

¹⁵ At the time of conducting the research, two main treatment modalities were available - medical substitution treatment and drug-free treatment. The former was provided by centralised statutory services generally in the form of short (usually 18 day) methadone detoxification programmes with some maintenance places available, mainly for HIV+ and pregnant heroin users. However, at this time, a small number of community based treatment centres had begun operation and, in addition, a number of GPs were also prescribing methadone on a private basis. Drug free treatment services were mainly of the therapeutic 12-step model which, on the whole, required the client to be drug free before accessing the programme. These latter programmes were the only ones accessible to heroin users under 18 years of age, as substitution treatment was not available for this age group.

not 6 months after, you need it straight away. [Frankie]

For the past two years now I've been trying to get help and only in the past three weeks now I'm getting it. [Kieran]

The heroin users responded to the lack of treatment by either staying using or attending addiction counselling. Others sought to do a 'home detox' by buying 'Phy' [methadone] either from a GP who was willing to prescribe, or on the street. Others went 'cold turkey' usually using a host of sleeping pills, Valium and alcohol to cope with the withdrawal symptoms.

Home detoxifications were for the most part unsuccessful. Ali's attempt was short-lived:

I started off detoxing meself, I bought it around the street, just bought a bottle of it, a 1000ml bottle, that would be about £90. I started off on 50mls and stayed on that for a week and then it went down to 45mls for say four days and then 40mls for three days and then 35mls like and so on down, and I got to about 20mls and I thought that I would have been able to go without Phy, go through it meself but I couldn't and I just ended up messing again.

Frank's attempt was more successful, albeit again short-lived as he ended up 'back on the gear' shortly afterwards:

I ended up doing a detox in nine days. I gave it up on four hundred mls, I done it well. I took a hundred one day and took nothing for two days, took seventy, and took nothing for three days, took twenty for a few days, then I had a hundred and fifty left and just drank it all. Just to get rid of it. Took no more, that was it, you know. Gave it up easy I reckon 'cos I wanted to give it up, this time you know.

Those who managed to access a methadone prescribing GP had mixed results. The expense incurred in doing this was almost as financially demanding as a heroin habit. Many were angry about the amount of money the GPs were charging for prescribing methadone, when the user was entitled to free medical care and prescriptions, as Simon related:

Like he is my GP and I still have to pay him fifteen pound to see him and then I have to pay to get the methadone. He's just, you know, he's money making. He's scamming like you know, Oh he has about forty, fifty patients up for the methadone. And like they're all giving him fifteen pound every week and like, half of them are, he's their GP and he won't write a medical card script out for me for my Phy do you know what I mean. Then you have to pay around twenty-three pounds for the

methadone when you get it in the chemist. Costs nearly thirty-eight quid a week. And I only, I get fifty-seven pounds on the labour. He's a wagon this doctor, like there's no-one like him. He's a legalised drug pusher. That's the way he is and making hundreds of pounds on it. Like he'd say at Christmas, well I'll be going away now for three weeks and I'll want three weeks money, you know. So that's forty-five pounds you have to hand him for three weeks scripts. And you have to have that. And this could just come out of nowhere like when you wouldn't have it with your labour and all like.

Ironically, for many, prison offered the opportunity, and the time and space to get drug free in a controlled environment, even if temporarily.

I've been in since May and it's done me the world of good getting me health back, putting some weight on, getting off the gear ... prison's not a nice place to be but it's a break to try get your head together it's hard but the minute you get outside the place the first thing that's on your mind is to get a bit of gear unless you really want to stay off it, the best part of people just get straight back into it all again. [Paul]

I think that maybe I'd be better off in prison. You know I've tried and tried to get help and I just, I can't, I just can't. I was talking to my mother about it last night in bed and I said I think I am better off going back into prison, at least you'd get a detox when you go in there. You know you get Physeptone free, for six or eight weeks, like a detox, then you get a sleeping tablet at night and that. You'd have loads of things to do, and you know it'll occupy my mind and at least I'll come out clean and hopefully, tip wood, I'll be able to stay clean. [Caroline]

Starting treatment

Starting treatment in the drug clinics necessitated a complete lifestyle adjustment. The 'ripping and running' associated with the continuous search for money and drugs and contact with their heroin network, was no longer necessary. The difficulties the heroin users encountered attempting this lifestyle change in their neighbourhood will be discussed in the final section of this chapter. First though, the focus will be on the problems they faced in the treatment programme they undertook.

Coping with rules and regulations

One of the key adjustments the heroin users faced was in having their drug use regulated by an external agency. During their heroin using career the main deterrents to using the drug tended to be financial and/or supply constraints. However, on entering treatment, the users found themselves having to conform to a

regime which not only regulated the amount of substitution drug they received but the time and place at which they had to take it.

The users were also faced with a barrage of rules and regulations which they found difficult and often humiliating to contend with. One of the more trying aspects of this regime was having to provide regular urine samples to check if they were using other drugs in addition to those prescribed to them, not that the heroin users weren't averse to trying to 'fiddle the system', but the manner in which the tests were conducted left a lot to be desired, as they related:

I came in here, I started three years ago now, and I'd been using fifteen years before that. I found it, and find it, very humiliating to have to come into a place like this. It is humiliating it really is, having to urinate with mirrors all around you and somebody watching you. [Hugh]

You don't get your Phy, if you've to give a urine, you don't get your Phy 'til you give your urine right 'cos you'll leg it without it. And if you've to go to a group [therapy] you don't get your Phy 'til after your group to make sure you go to the group, and if you don't go to the group, yeah, you'll get cut ten mls right, so you'll always make sure you go to your group. [Anthony]

It's just a big deal to get Phy you know, you know. Obey the rules or you're not getting it. You know what I mean, like stupid. Like they have signs up at the clinic - If you do this you're going to be docked five milligrams of Phy. You know what I mean, crazy shit. You know shit like if you're late you won't get it that day, you know all this, stupid, stupid rules, you know. [Frank]

Adjusting to the medication

Many of the heroin users who had taken methadone previously, as part of their drugs repertoire, found that the level of the drug prescribed in the treatment centres, while sufficient to 'hold' them, did not produce the effect they had associated with the drug. Coping with this paradox was difficult for the users, as Hugh explained:

I think that the concept of giving out a drug, people take drugs to get stoned, for the buzz, and the concept of maintaining people on a substance that is not only far more addictive than heroin but also doesn't fulfil the function of taking the drug seems like pointless to me.

The loss of 'the buzz' from drugs was one of the most difficult aspects of treatment, as the heroin users related:

It does my fucking head in sometimes because I like to get high. I do, I do like to get high, I admit it, you know what I mean. I just, sometimes it really bugs me. Because I miss it you know. [Rory]

It's not just as simple as everyone thinks it is you know what I mean. Give him Phy, he's on a hundred mls or whatever he started on. That hundred mls is great. When you come down to forty mls you know what I mean it's completely different. You're walking round just normal like everyone else is walking round. But you don't even want to be like that, you want to be a little bit high off the ground as they say, and like that forty mls is not doing you. You want to go out and you want to score gear or you're going to take more Phy on top of it. You're going to go out and you're going to buy some off someone a fella who has it, out of a chemist or whatever. Or you're going take a few tablets or you're just going to do something to give you a kick you know what I mean. [Steve]

Topping up

Dissatisfaction with the level of medication they received was one of the recurring themes in the heroin users' views on treatment. In addition, further difficulties were experienced by the users when the treatment clinics introduced Methadone as the substitution drug for heroin, in exchange for the traditionally used Physeptone - as occurred during my field work. A key aspect of this change was the psychological adjustment it entailed, for one the quantity was smaller¹⁶, it was also perceived to have less of an affect, as Joni described:

Like on the brown Phy I never woke up sick. But like now, with that green Phy like I know they say it's the same strength and I'm not like conscious of like that there's just half the dosage, I'm grand that I don't have to be putting all that sugar in my body because I get a rash from it, there's just too much sugar in it. But I honestly think that it doesn't hold you and like I do be dying sick before I go to bed at night ... But all I know is, I was grand on the brown Phy but this green Phy, it doesn't even heat you up. That was great about the brown Phy like when you drank it like you'd automatically you'd feel warm do you know what I mean like but that green Phy it didn't warm me up at all, it doesn't.

Jack had a similar view of the changeover and was frustrated by the lack of understanding from the clinic staff:

They have all that green Phy in here, it's not the best you know. We had the brown Phy in, that was nicer. Like I get a hundred and twenty five mls of Phy here but I mean I do be still sick when I wake up in the

¹⁶ Physeptone was 2.5 times the volume of Methadone i.e. clients received 20mgs of Methadone instead of 50mls of Physeptone.

morning you know, sniffly nose, runny eyes, pains in me legs. But you tell them this and they don't want to know, you know what I mean.

This dissatisfaction coupled with a longing for a 'buzz' led many of the users to top up the level of medication they received. And, as the urine tests were not quantitative, the users related how they were able to take additional methadone without jeopardising their treatment:

When I was on the maintenance in Trinity Court I was still buying Phy then and I'd be taking three hundred and four hundred mls of Phy before I'd go in so it wouldn't show up. You know what I mean, it'd show up 'cos I'd have Phy in me system already and that's what I was doing for ages you know. [Annette]

I take 'geansai' loads of Phy, they give me only a hundred and fifty mls but I'm taking nearly five hundred mls nearly every day. [Charlie]

However, those who topped up on their methadone when they were on a short detoxification programme found themselves reaching the end of their official detoxification with a Methadone habit. And, as Susan and her partner discovered, there was little treatment available after you'd become 'hooked' on Methadone:

What happened was when we started detoxes we started off great and then I got the chance of a bottle of Phy and I took it. I bought the bottle. It was sitting in the press and we were topping up on what they were giving us and you're not supposed to do that 'cos they're cutting your strength but I was topping up more because when we came in here on Phy they didn't know what to do with us because we're not your normal heroin junkie. Like and there's nothing to come off Phy with.

Using benzodiazepines

Another strategy employed by the heroin users to counteract their dissatisfaction with the level of Methadone they were prescribed was to use benzodiazepines to boost its effects. As Masie related:

It's just your Phy sometimes doesn't do anything for you, you know. Some days when you're depressed and that, it might kill your sickness and that but you want to feel a bit, you want to kill the depression. So you go out and you buy a few Valium or you'll buy a few Rohypnol outside just so as you can feel a bit normal and happy in yourself or whatever ... And when I take a few Benzos and that along with the drop of Phy like, I can go home and I can sit down and play with them [her children], and read them stories and can cook a dinner and clean up and I don't want to know about the problems or they don't come into me mind and I can deal with life much more easily.

A prescription for benzodiazepines was relatively easy to get off a liberally prescribing GP, as Simon described:

I was detoxing and I went down to this doctor. I was down to twenty mls of Phy. And I was you know, I couldn't sleep and I was restless and I was going through withdrawals and all. And I went up to him and I said to him 'Doctor, I can't sleep with this I'm restless and I'm going through very strong compulsions' and I says 'I don't know what's happening anymore'. And he writes me out a month's supply of these tablets, Dalmaine 30, a month's supply of Mellaril tablets right and then, another month's supply of Diazepam 10s right and I was to take, I remember, two Mellaril tablets a day, three Diazepam 10s a day and one Dalmaine 30 at night. And I was saying, but like I says well I'll take me two now and I started you know, started getting stoned, kind of, you know. I didn't know what I was doing then, I just starting putting loads of them into me mouth and I came in here and I 'slipped' and I was put back on the re-entry [programme] and all over it.

However, the users found that different clinics had different rules about the use of other drugs. Some allowed their clients to take benzodiazepines along with their Methadone while others strictly enforced a Methadone only policy, as Jack discovered:

The likes of the X clinic now they can take anything like Benzos, they're out taking Rohypnol, banging it up. The only thing they're not allowed to take is gear. But down here you can't touch anything you can't even have a drink in here.

Failing treatment

Falling foul of the treatment agencies' rules and regulations was a regular occurrence for the heroin users and particularly for those on detoxification programmes who seemed more rigorously policed than those on maintenance programmes. Some of those on the 18 day detoxification programme ended up being suspended from the programme for infringing the rules, others found that they relapsed shortly after treatment ended. From their perspective a key difficulty with these short programmes was the abrupt ending and the lack of after-care. As Sadie described:

They do an 18 day detox, why they won't do it more slowly, you just can't just stop using in 18 days. When they start the detox, they start you on 75mls, you get that for 3 days and then you're brought down 5mls each time and then you finish on 5 mls on the 18th day, that's it, you don't get no aftercare or anything and that's when you need help, that's when you need someone to talk to, because you're withdrawing from the Phy plus the heroin, you know the heroin has gone out of your body but then you've to withdraw from the Phy and that's 10 times

worse, but that's the way they leave you, on the 18th day you get your 5mls of Phy and 'good luck', that's it, you get no counsellor, you get no social workers, you get nothing, you walk out that door and it's up to you whether you say yes or no to it.

As a result, most of the heroin users underwent numerous detoxification programmes with little success:

I was in Beaumont about six times and in St. Michael's once getting stabilised, yeah. Then I was on Pearse Street and then I went for detox about four, four times, four or five times. [Mark]

I tried to get clean, tried to detox meself loads of times and it just didn't work. I was with loads of doctors, I was in Cherry Orchard Hospital getting detoxed. Nothing worked for me do you know 'cos when I'd take the detox and I'd come off the detox I'd be lost and I'd run back to drugs you know ... I couldn't get off heroin. And I started taking Phy and I got addicted to the two of them and you know it was hard. I remember trying loads of detoxes. I tried more detoxes than I can even remember. Never worked for me. I tried N.A. I tried everything like that but none of them worked for me do you know. I'd always turn back to drugs. [Kathy]

Lapsing

Ironically, by attending the drug treatment clinics the heroin users had to face the dealers who congregated outside, and even inside, the clinics, which sometimes facilitated relapse, as Maria related:

You're only in there with people that's either selling drugs or something and that bugs me. Even sitting in the clinic in there waiting for your Phy or whatever, they're people selling on the premises you know what I mean when people is honestly trying to come off, it's no joke. And you have to put up with it, and it's very unfair on people that really wants to come off it. Some people only want a break you know, just want to come off it.

However, having the strength to say no was particularly difficult if you were going through a bad time, as heroin was often the first thing the users thought of to comfort them, as Annette described:

It's like, what frightens me is that whatever it is about it you still go back you know. If something happens in your life it's the first thing you run to and that's why you have to learn just not to run to it you know. It's crazy.

For those who lasted the duration of a detoxification programme, relapse was commonplace. For many, using heroin again had an initial upside with return of the

familiar and welcome 'buzz' they felt when they had first used the drug. However, this was generally short-lived as old difficulties, such as the re-emergence of their 'sickness' followed shortly afterwards. Some, were under the misguided belief that if they started using heroin again, particularly if they smoked rather than injected it, that this time they would be able to control their use, but for those I spoke with this was not the case:

The very first time I picked up drugs again I was only just smoking you know and I was grand and stoned out of me head, it was great. I thought this is brilliant, this is like smoking heroin at the beginning you know. And it didn't take a week, wasn't a week between that and being back on the needle and being dying sick. [Samantha]

I'd a lot of times when I'd finish me detox and I'd go straight back on it. I'd only be off it one day and I'd be straight back using and that. 'Cos I thought it was just the physical side of it. Once I got together, you know, once I was back together, I'd be alright and I could use once a week. But it didn't work like that. [Sinead]

Only a few weeks after you'd be strung out again. I mean you'd start off with just a little 'cos you'd have no tolerance you know, and before you know it, you're back to stage one, know what I mean. Like you were robbing everything and taking as much as you could get. [Anthony]

However, with treatment places in short supply, accessing treatment after relapsing was difficult as the heroin users faced long delays before they would be allowed back on a programme. And, in the meantime, their 'habit' worsened, as Susan found:

If you fail an eighteen day detox in any clinic you have to wait three more months before you can get another appointment and then it'll probably be six weeks after that appointment, so it just means you've time to get strung back out, when they haven't even finished the detox in the first place.

Withdrawing from methadone

For those who stayed with the methadone treatment programme there was great trepidation at the thought of going through the detoxification process and the repercussions that might follow, such as relapsing, as Jimmy described:

Like I'm even afraid to come off it do you know what I mean. Like you know when you're working people say would you not come off that but I'm afraid to come off and end up using again, like my sheet is clean you know what I mean since I started here, so why should I mess it up.

There was also a widespread perception among the heroin users that coming off Methadone was even more difficult than coming off heroin, as Jack related:

You'd be sicker from the Phy more than you would be from gear you know, it's horrible like.

The belief that Methadone 'seeped into your bones' was another common perception, as Susan described:

It seems easier to get off heroin. 'Cos the Phy is in your bones do you know what I mean it sets right in and it has to come out of your bones. But where the heroin is just in your blood system you know what I mean. Like it is a known fact that it's harder to come off than heroin.

This concern translated into a wish for a gentler detoxification that was more attuned to their needs than the clinical view of best practice at that time, as Joni described:

Especially now like I'm taking Phy constantly for about two year, two and a half year like and that gets into your system do you know what I mean like and I mean you can actually be worse being strung out on Phy than gear. 'Cos the Phy just gets into your bones and it's oh it's, I don't know, it's different. It seeps into you like especially when you're taking it for a long time. And so to come off it like, I want to do it very, very slowly, do you know what I mean. At me own pace, not at their pace, because I know if I do at my own pace, I won't feel it. I know they're the doctors but I know meself and to do it proper I'd want to do it at me own pace and like I'd be fair and say like I'd cut another five mls and if I cut meself too quick well I'd say hold on wait another week. Although you wouldn't miss five mls do you know, no more than you'd feel five mls if they gave you an extra you know five milligrams. You wouldn't feel it you know what I mean. But if they're cutting you five mls every three days, after a couple of days you're going to feel it 'cos you're going down so quick. To do it proper like you'd want to do it very slowly.

Effective treatment

Despite the many misgivings and difficulties the heroin users experienced with the treatment they were offered, their views of treatment were not always negative. Some saw the main benefit of substitution treatment, as Sean described, as "taking away the worry of having to score everyday". And as Damien explained:

At least you're not out there running and robbing all the time you know.

Susan found she could live a more 'normal' life while she was in treatment:

Like since I came here [drug treatment clinic] I haven't been stoned. And the longing for it is unbelievable, do you know that way but I don't, I don't want to go back 'cos I'm normal since I came here, I can live a

normal life you know what I mean. You can plan other things.

It seemed, in particular, that the heroin users who had accessed one of the new community based treatment centres, found the less regimented approach there easier to cope with compared to other clinics they had attended, as Steve described:

Like they don't throw you off, if you come back and give a dirty urine they don't throw you off straight away you know what I mean. They look at your progress and see how you're doing, see how committed you are to the programme, like they have groups and like you can't take the Phy without the group you know what I mean. You have to do these groups. they'd say to us, we were doing like English and Maths classes. Not like school but like getting you back into reading and writing and being able to do things ... like we're going out this Saturday we're going up abseiling in Dalkey first, then we're going on a speedboat round Dun Laoghaire harbour which is good, you know what I mean.

These community based treatment settings provided a wider range of support and complementary therapies, like acupuncture, which their clients rated highly. The staff were also regarded as being more supportive, taking time to develop more personal relationships with the clients, as Annette related:

Like in X clinic, you're just, up there, you get called, you get your methadone, that's it. They don't talk to you, you know what I mean, you're just another junkie you know what I mean to them. They don't take pride in their job, they're just there to hand it out and that's it, next. But in there like [community centre], you're part of the place, do you know what I mean like. They know you, they know your family, they talk to you like 'how's the kids' and like they're involved in your life you know what I mean.

Life after Methadone

Those heroin users who had accessed one of the few methadone maintenance programmes, found, after a time, that they wished to move on and detoxify completely from medical treatment. Tony, for example, had come to realise the restrictions his maintenance programme was having on his life:

Like at the start, before I was starting, they were saying do you want a maintenance or a detox and I was saying, 'What's the maintenance? like are you on it the rest of your life and all'. She goes 'Yeah, that's for the rest of your life' and I was yeah, fucking right, for the rest of me life so I'll be on a buzz for the rest of me life and no-one can moan about it, so I was delighted I just jumped for it I did, no better bleedin' man you know that way. I was delighted. And then when I started here [rehab.] in November they were, you know the way they talk about everything and all, and I was just realising that I'm going to be dependent on that

for the rest of me life like so that could hold me back with job prospects or anything. Like I would have had to think about it. I would have had to work around me Phy. Do you know what I mean. So I told him, I told the doctor then, so then they started cutting me, doing the detox, the slow detox.

The realisation that the control heroin had imposed on their lives was now replaced by a controlling treatment regime, lead these users to decide that it was time to wean themselves off the medication and the hold it had over their life.

I'm on fifty mls of methadone and I hope to be off that in the next three weeks. 'Cos like I'm fed up with it like you know. It's just, it had a hold on me like, and the hold it had on me like was like I hadn't got a say like in what I could do. [Mark]

I got put on maintenance in the Clinic, they give you Phy for the rest of your life and I said no. I said I don't want that, I want detox I want to come off it, I don't want to stay this way for the rest of me life. It was almost as if the drugs were still tainting me. Like I'd be watching something on the telly and you know, we'd have to run in case the clinic closed and you know, stupid things like that. It was like as if the drug was still dictating my life and I didn't want that do you know what I mean. [Sarah]

You get tired coming over every fucking day you know it sort of controls your life you know what I mean. If you've somewhere to go you can't go 'cos you've to go to the clinic first and you'll come over in the mornings and they'll say you know, come back after dinner you know. [Jack]

Negative views of methadone maintenance programmes expressed by both the heroin users and the key informants, seemed at odds with the ongoing community campaigns for additional methadone treatment services. However, over time I began to appreciate their concerns that methadone alone would merely contain the problem in the neighbourhoods and that the long-term solution had to be more than about treatment; it also had to address the root cause of the problem - poverty, disadvantage and social exclusion. Otherwise, as one community activist described, only the 'tip of the iceberg' was being tackled. This view was supported by the experience of the 'treated' heroin users in terms of the issues they had to contend with while living in the environment which had facilitated the development of their heroin career in the first instance.

The local environment

Studies of self-recovery by heroin users have shown that changes in lifestyle and environment play an important role in pathways out of addiction (Robins, 1973; Waldorf, 1983; Biernacki, 1986). However, with treatment orientated at the level of the individual, the heroin users seeking to cease the use of the drug were still faced with having to cope with everyday life in their neighbourhoods, where heroin was easily accessible and was still being used by their former peers.

Coping with the availability of heroin in the neighbourhood

In Chapters Four and Six, I described how the dynamics operating in the neighbourhoods were conducive to accessing heroin and developing a drug habit. These same dynamics, in turn, often proved detrimental to the heroin users' attempts to give up and stay off the drug. Heroin is so embedded within these communities that according to Terry you'd need to leave the area in order to be able to stop using:

You'd have to get out of Westown if you want to stay away from gear, it's just drugs, that's all there is.

For the users who were attempting to stop using, the open dealing scenes in the area were a constant reminder and temptation to use, as Lucy described:

Like it's hard as well when you can't walk from your house to the shop and you see so many selling it d'you know what I mean and people asking do you want it.

Access to the drug is so easy, that it's hard to maintain the resolve to stay off, as Anthony related:

I mean, there's so much gear around, it's like an alcoholic like. It's very hard for an alcoholic to stay out of the pub if he's walking around the street and the pub's on the street, do you know what I mean? And that's the same for drug addicts like. Even if you try and avoid the street where the gear's getting sold, you still bump into people that turn around and say there's lovely gear's getting sold down there or a young fella would come up to you and say, are you looking for anything or whatever, you know what I mean like?

Many of the users tried to distance themselves from what was going on around them by staying in their homes and avoiding contact with the scene, as Simon did:

It's very hard for me to say no, you know when it's in front of me and you know like right now what I do is I go home and I try and I get a film and or else I go swimming. I just try and keep away from where the drugs are. You know, I kind of isolate meself too as well because I know like it's not safe out there you know, for me. You know like now I can, I do pass by and like I've been asked are you looking and I'd say 'No', you know, I'd say, 'No I'm not'.

Frank similarly recommended this course of action:

Now if you're hanging around in a gang, you're going to have to hide in your gaff to give it up. 'Cos as soon as you go back out you're going to meet someone that's on it.

The former users also had to cope with the attitudes of their neighbours who still regarded them with suspicion, as Rory found:

And do you know what's really sad about it is, that if you want to come off it, especially in an area like this or where it's really bad, once you're on it and you've been seen you're stereotyped. So you have to fight that as well, you know what I mean, you've to fight people putting you down and not accepting you. Like the people that were clean don't want to have anything to do with you because you've been seen with people mad out of it and things like that.

Coping with friends and family who were still using

In addition to resisting the temptation of the plentiful supply of drugs in the neighbourhood, the users also had to try distance themselves from the network with whom they had bought, sold and used drugs over the years they were involved in the heroin scene. This was particularly difficult when their former peers were still using in the area:

It's really hard. Like because nearly everyone around here is on drugs and like the only friends that you've known for the last three year is them that take drugs. And it's just a routine, and like a life that just revolves around it and it's very hard to go different when you're after knowing someone for so long. So it's hard like to just turn and then you have them saying 'ah she forgets herself' you know, so you've all that as well. [Tina]

It can be very hard because I've had to stop hanging around with everybody out there you know, so an awful lot of friends that I would have had I would have lost all them you know, the people that you've grown up with all your life. It's very hard to break away from that you know. So I have nobody out there. And I'm out there completely isolated, away from everybody and everything. [Samantha]
You know one thing, it's a very hard drug to get away from. Especially

around here because, it's still like all around you. You know, like I had to totally isolate myself from all my old friends, I don't give any of them a call anymore, and that's like hard sometimes you know 'cos I was looking at them, they'd be all stoned out of their heads or whatever and I'd be saying they're having a great time, but then I'd stop and say no they're not. It only looks like they are. Some of them would slag you off but like, I just let it roll off, you know. But some people would, that's how people go back on drugs, because like the pressure around them. Like I'd stop to chat to them, but I won't put myself in a situation where like there's people using gear. But I stop and talk to them in the street or whatever and they'd offer it to me, they'd say, 'do you want to come for a blow around'. And I'd say no I'm off it, or whatever. But sometimes like I do feel like going for a blower you know. That's how hard it is.
[Peter]

There were mixed views as to how far people were put under pressure by their former drug-using peers and dealers to start using again. Joni's experience was that:

people like they're offering me gear everywhere and they know quite well I'm only out of Beaumont [hospital residential detox] and all like. There is some people who just love to see you down. They just don't like to see you getting on and getting things back. I don't know, it's almost as if they wished to see you bleeding fall you know what I mean like.

But others, like Frank, disputed these stories:

Like they're more than likely, it's going to be you being too weak to say no, rather than them, they're not going to hold you down and fucking put it into you. You know what I mean, you do have a choice it's just, it's very hard. But like they're not going to come after you and make you take it. You hear stories you know, it's being exaggerated you know, people that say that probably just won't admit that they hadn't got the strength to say no.

However, for those living with other drug users the close proximity to drugs was problematic and difficult to avoid. As described in Chapter Eight, many of the users also had family members and/or partners who were using heroin. For those who had a drug-using partner the view was that both of them would have to give up together, or the one who wished to give up would have to move away from the partner who was continuing to use:

We were together three years, it was the hardest decision I ever made, between giving up the drugs and him. Both of them are gone, the only thing I have a problem with is drugs and that do you know what I mean, it was a very co-dependent relationship you know and looking back on it now, the only thing we had got in common was drugs. [Sarah]

Like I'm really trying hard, to stay clean, like I got away from me fella,

broke away from everything and I'm going out with a different fella, the two of us are on here together and the two of us are trying together.
[Jessie]

For the female heroin users moving away from their drug-using partner appeared, logistically, easier as many had their public housing tenancy in their own name – it being easier for single mothers to access public housing on their own. However, for many of the young male heroin users living at home, there were less accommodation options for them if they wished to move out of a household where other family members were continuing to use. The pressure on those who attempted to give up using heroin in these circumstances was immense, as Kieran, whose brothers were still using, described:

I don't want anybody that's on gear in the house. I keep telling him I don't want anybody near the house that's on gear 'cos that's not fair on me I'm trying to get off it so it's not fair on him bringing in people on gear. Like a friend of mine knocked into me the past four nights in a row, he's on gear now, and he knocked into me with loads of gear, giving me gear for nothing and all and I says 'listen I don't want it I'm trying to get off it' you know what I mean, 'I don't want it' I says 'I'm not being smart or anything but don't be coming to the house' do you know what I mean. And yesterday morning now, me brother had him in the house smoking gear, I said 'I don't want you near the house' its not fair on me and me girlfriend we're trying to get off drugs, we're upstairs watching telly and they're downstairs doing drugs.

Learning to replace the routine

In addition to coping with the availability of drugs in the neighbourhood, and the lack of non-drug-using peers to hang out with, another key difficulty was finding things to do to occupy their time. None of the heroin users who had given up at the time of the interview were employed. A small number were on special training courses or in treatment programmes which provided education and leisure activities. However, the vast majority had little to do for the day and little money to spend on entertainment.

Because many of the users had started their drug-using career at such a young age, the 'normal' transition from youth to adulthood had been impaired by their drug use. Consequently, as Rory described, you don't know what to do with your time:

It's just breaking away from friends. That's difficult. That is very hard. And then not knowing what you enjoy or what to do because you've spent most of your time walking around the streets and getting high so that you don't know what you're good at.

Ironically, even though tiring of the lifestyle provided an impetus for giving up heroin, many missed 'the buzz' and found it hard to fill their hours and days. The emptiness of people's lives, which had prompted their use of the drug initially, still faced them when they gave up using heroin. And, filling the social void left after the routine of using drugs had gone was difficult, as many of the users explained:

Your day becomes totally focused on that little bag of heroin. Everything must be about that, getting that. And so when you take that out of your life, you're left with a big hole and what are you going to do now. Certainly one of the bigger problems that you have to deal with is that all of a sudden you've got ten hours of a day or whatever to fill. And yeah you miss the buzz of getting it and going home and doing it, you certainly do, I do anyway. [Sean]

See that's part of coming off drugs as well like, when you're on drugs it's something to do about getting the gear and you know whatever, like people miss that you know what I mean when they're coming off drugs. They miss the idea of getting up, getting a syringe, getting everything together, making it up, going out scoring and stuff like that. They miss all that. And that's what's happened to me, 'cos I'm just sitting in the flat doing nothing, watching the television. Ask me about any show on TV and I'll let you know about it. [Maria]

Yeah, you do be very bored. Like there's nothing to do, do you know what I mean. When you're, when you're strung out, there's not enough hours in the day for you. When you're on this [methadone treatment] then there's too bleeding many. But like when you're on the Phy you just have all day to yourself, to do nothing. You just catch your Phy but that only takes ten minutes, then you're back in the house again doing nothing, watching the telly. [Rose]

Those who had been involved in the dealing of heroin missed the status of being the local 'cool cat' in the neighbourhood, as Rory admitted:

I think losing the image for me was the hardest. Not being the hard man you know.

With little to replace the junkie lifestyle, many found themselves isolated and found normal everyday activities difficult to do for some time, as Annette, who found it difficult to mix with people who hadn't been drug users, related:

For ages I couldn't sit in a pub like with just people that hadn't touched drugs 'cos you feel real out of place that you don't fit in, you know, you're not into their buzz like, but now like it's okay, for a while you're saying 'I'm not into this' you know and you only feel comfortable with people that are on drugs.

Conclusion

This chapter has outlined the transition points in the heroin users drug career which prompted them to attempt a drug free lifestyle. Factors such as the ongoing 'sickness'; poor health; lifestyle dissatisfaction; legal difficulties; the impact on their families; the cost and erratic availability of the drug, were identified as being significant. However, the heroin users were faced with a plethora of structural difficulties with regards to accessing treatment and the limitations and constraints in the type of treatment available which hampered them from capitalising on the opportunity these transition points provided. After years of being immersed with a lifestyle which revolved around their drug use and a peer network of other heroin users in the same drug-centred environment, the lack of alternatives to a drug career posed an almost insurmountable challenge to their attempts to give up and move on from their heroin careers.

Chapter Ten

Discussion and Conclusion

Introduction

This thesis took as its starting point the concentration of problem drug users in poor areas of Dublin and sought to examine the development of heroin careers in the context of these neighbourhood environments. In so doing, I used the concept of social exclusion to shape my exploration of the social, cultural and structural processes that influence the lived experience of socially excluded spaces, and to consider how this experience relates to the high level of problem drug use in these neighbourhoods.

In this final chapter, I wish to bring together some of the key issues which this research study has identified in relation to the two phenomena – neighbourhood drug problems and social exclusion, and then discuss the implications these have for social theories and policies, and for further research. To conclude, I will comment briefly on the situation in the neighbourhoods since the completion of the field-work for this research study.

Note on methodology

The methodological approach of critical interpretivism and the analytical process of triangulating quantitative and qualitative data with ethnographic insights allowed for an in-depth appreciation of the complex phenomenon arising in excluded spaces - an understanding which, I believe, would not have been possible by the use of one method alone. However, while the complexity indicated by this study highlights methodological deficiencies in the linear, cause-effect assumptions of positivist research, it would be misleading to suggest that this study's findings are universal, generalizable or replicable in other places and spaces in that they are based on a sample of drug users and socially excluded neighbourhoods of unknown representativeness. Nonetheless, the continual repetition of pattern which emerged from my analysis, and its fit with the broad sweep of literature which had been consulted, suggests that this study is a valid portrayal of how drug careers interact with and are shaped by the external environment in which they develop and so

offers a greater understanding of the complexities involved to inform future related research and policy development.

The dynamic of social exclusion

The analysis of quantitative socio-economic data, in Chapter Four of this study, demonstrated how fundamental components of social exclusion (such as poverty, educational disadvantage, chronic unemployment etc.) were highly prevalent in the five neighbourhoods studied. However, by examining in addition the lived experience of these phenomena, this study noted that components of social exclusion are not just cumulative but mutually reinforce each other when they are experienced in the same socio-spatial environment. In this sense the experience of one component appears to trigger, or be a consequence of, another, thus intensifying the experience of exclusion for the individuals, families and communities concerned in a multiplier effect.

For example, we have seen how unemployment - in particular, the chronic long-term 'joblessness' which was the predominant experience in the heroin neighbourhoods - impacted on the residents in a multidimensional way resulting *inter alia* in welfare-poverty; a lack of routine and structure in individual lives and for the neighbourhood as a whole; and the amplification of social isolation. However, these factors were also seen to criss-cross and interconnect with other structural factors and social processes in a complex and dynamic way. Social isolation, for example, was also seen to have been engendered by ghetto-creating housing policies which physically isolated the disadvantaged working class from the rest of society and contributed to their stigmatisation with knock-on effects, such as reducing the opportunity of hearing about jobs through social networks, and/or being discriminated against by employers and others because of their address.

The drug-exclusion nexus

This spatially-located dynamic of social exclusion was seen to influence the development of heroin careers among those caught up in its path, in turn reinforcing the problems of the excluded neighbourhoods (as illustrated by Currie, 1993; and Wilson, 1997). For example, both unemployment and early school leaving shaped the

context for individuals embarking on a heroin career in terms of the capacity of the drug and its associated rituals to fill the vacuum of their post school, non-working, lives. Furthermore, the informal economies operating in each area, themselves a product of poverty and the contained social networks in isolated neighbourhoods, facilitated local drug markets and the ready availability of heroin - so 'you wouldn't have to go look for it' - thus providing easy access to the drug to more people in the neighbourhood. In the narratives of residents, we heard how the sale and use of heroin became routine, how life revolved around the drug, and impacted on the trajectories of young peoples' lives so that it was difficult to go a different way.

Social networks

Further aspects of the neighbourhood dynamic were seen in how social exclusion and physical isolation impacted on the social networks of those living in the areas. This research study demonstrates how social networks affect drug use in a number of ways such as enabling the circulation of drugs and information on how to use and where to score. However, as Zinberg (1984) and Grund (1993) have pointed out, social networks also influence the 'setting' in which drug use takes place and whether this drug use is compulsive or controlled. Their view that heroin users' range of social connections (such as knowing more compulsive users and fewer controlled users or users of non opiate drugs) and their lack of participation in non-drug related activities, cuts off the heroin users from the limiting influence of more moderate drug-takers, and leads to more compulsive use. In this study, the data suggest that the constricted social networks shaped by the socially excluded environment may contribute to the dynamic of social exclusion and drug problems in that the more people there are using heroin in an area, the less alternatives there are in terms of social relationships and activities, and the more likely that drug use is not controlled.

The social exclusion dynamic

The examples above illustrate how components of social exclusion mutually reinforce one another in a manner which suggests more than a co-incidental accumulation of disadvantage and social exclusion. This finding resonates Fischer's (1980) view that the critical mass of people experiencing disadvantage in an area resulted in a synergistic situation whereby the overall level of disadvantage was greater than the

sum of its parts. The dynamic aspect of the synergy implied by Fischer (what may be termed a *dysynergy*) is mirrored in the amplification of social exclusion portrayed in this study, and indicates the level of complexity involved in the interconnectedness of its components.

Conceptualising the risk environment

The research literature which identifies individual risk factors and risk groups with a vulnerability for developing drug problems tends to acknowledge, but otherwise isolate, these risk groups and factors from their broader lived environment. Even studies (such as the ACMD, 1998; and Lloyd, 1998) which point to the overlap or interconnectedness of risk factors and their environmental context, do not examine in detail the impact of the spatial concentration of risk in particular neighbourhoods.

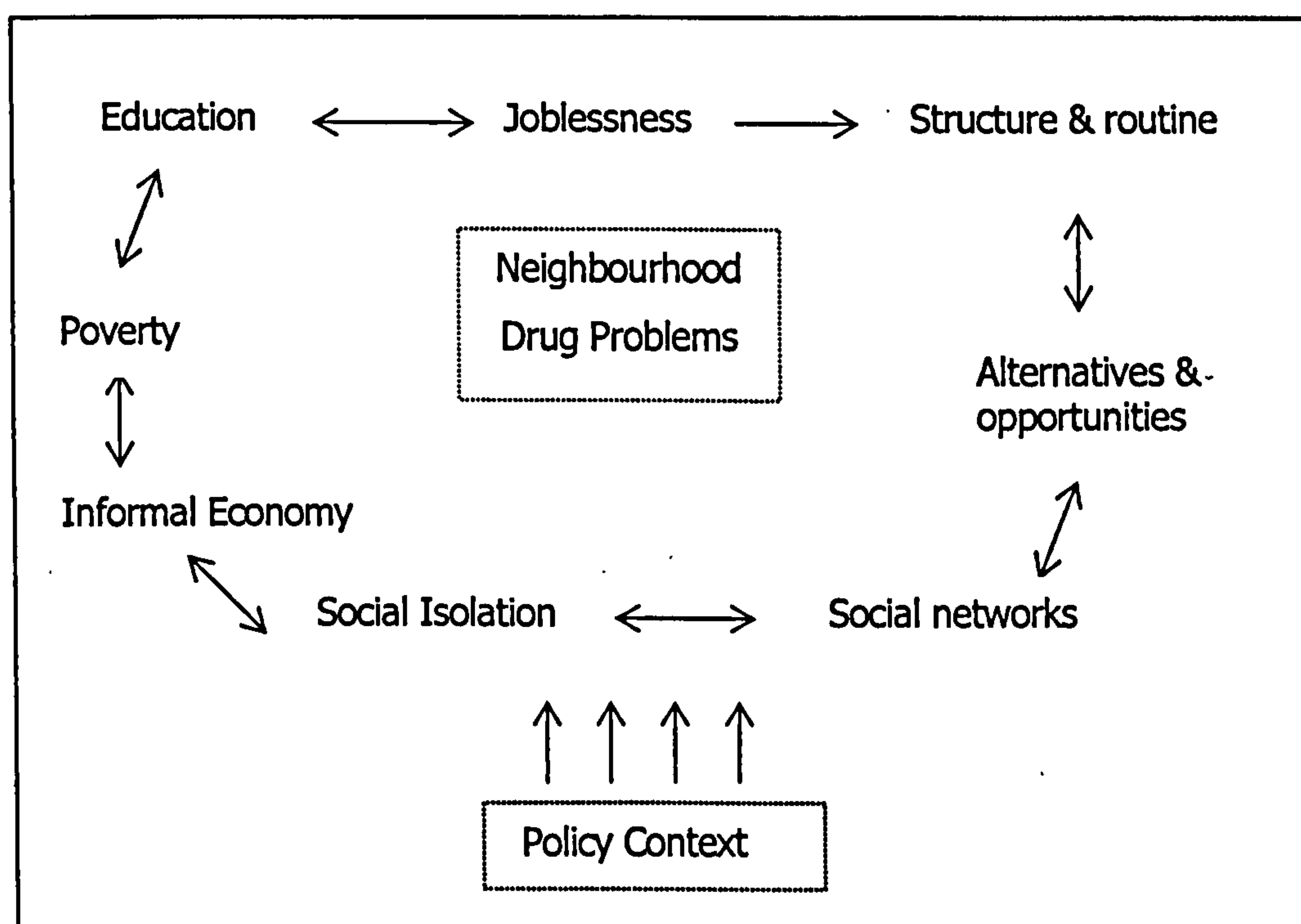
In analysing the research data for this study, it was possible to identify components of social exclusion common to the five heroin neighbourhoods. The interlocking nature of these components suggests that it may be useful to develop the concept of the 'risk environment' as a unit of analysis in drugs research, not just in the manner suggested by Rhodes (2002) in terms of reaching a broader understanding of the factors which influence risk, but also by constructing a matrix of variables which when found to co-occur in the same socio-spatial environment could act as an alert that an area is a 'risk environment' for drug problems and inform the 'drug-proofing' of broader urban and social policies.

To develop such a concept of the 'risk environment' would require a methodology which could capture the dynamic and complex social systems in excluded areas. In this regard, Byrne (1999, p4) exhorts the need for a synthesis which moves from a focus on the individual, as the object of measurement and conceptualisation, to a recognition of the dynamic character of social process and to integrate the individual with the social entities through which they live their lives.

It is of course a moot point that the composition of a risk environment may differ in time and space. For example, how relative are these Dublin neighbourhoods to the African-American or Hispanic neighbourhoods described by Wilson (1987, 1997), Bourgois (1989, 1995), and Dunlap and Johnson (1992) among others? While there

are merits for constructing the components of a 'risk environment' which is culturally, spatially and temporally relative, its utility as a concept would be in defining core components which are pretty much universal. We can catch a glimpse of how such a concept might be constructed from the common factors found between this study and Wilson's in terms of extreme economic marginality, joblessness, lack of neighbourhood resources, isolation from mainstream networks etc.

Figure 10.1: A risk environment for drug problems



Social exclusion v. social disorganisation

The similarities in the findings from this study of Dublin neighbourhoods with the neighbourhoods studied by Wilson does not, however, suggest a similarity in how these findings have been interpreted. Wilson's interpretation was that these factors provided the context for social disorganisation in the neighbourhood, rather than noting how they were inextricably linked. Furthermore, he interprets these as arising from the 'unintended' consequences of economic restructuring. In the Literature Review of this thesis, I indicated that the utility of the concept of social exclusion, over that of social disorganisation, is its capacity to focus on the process and the

forces by which people are being excluded and locate spatialised social problems with policies and structures rather than with individuals, families and dysfunctional cultures. In this respect, the works of Byrne (1999) and Young (1999) are particularly useful in illustrating the connections between socio-economic policies, their ideological underpinnings and social exclusion.

Identifying the uneven impact of changes in post-industrial society, and how exclusionary public policies and practices influence the development of socially excluded neighbourhoods, is important in countermanding the notion of the 'underclass' subculture popularised by Murray (1990, 1994) and others in the 1990s which has had such a detrimental impact on social policy in much of the 'developed' world. Their emphasis on the normalisation of welfare dependency, lone parenthood, crime and drugs in poor neighbourhoods, and the consequent cultural isolation of their residents from mainstream society - as if this situation arose independently from any socio-economic context - is seen, in this study in any case, to be a misleading interpretation of the issues.

The meaning of localised drug problems

In the excluded neighbourhoods examined in this study, we saw the attraction of heroin being part-palliative, part-thrilling, in that the desire to use and continue to use heroin stemmed from the relentless grind of boredom and the harshness of life for the mass of young people hanging around, out of school and out of work. In this context, pursuing a heroin career provided a routine and structure to the day, it was also seen to give status and prestige in circumstances when there were few 'legitimate' opportunities to do so.

Indeed, the female heroin users in this study were as equally prone as the males to describe the attraction of a heroin career in terms of its status and accompanying lifestyle. Despite concern that these issues had been identified in studies of, invariably, male heroin users, and consequently may not apply to females (ACMD, 1998), this did not prove to be the case. This finding may reflect the changing role of women in society and may also help explain data indicators of an increasing proportion of women using heroin.

Opportunities and alternatives

The issue of alternatives and opportunities, legitimate and deviant behaviour are a recurring theme in this study. In environments with scant opportunities to acquire 'legitimate' status the active addict lifestyle, and its accompanying rituals, was one of the few identities available to alienated existences. In addition, the pleasure-pull of the drug - described so compellingly and consistently by the heroin users as 'taking all your worries away' - was seen to have a particular resonance in the context of their neighbourhoods where poverty and social exclusion were dominant experiences. In this sense, the desire to continue returning to a heroin-induced state of bliss seems best understood in the context of the absence of alternatives (see also Chein *et al.*, 1964; Peele, 1985; Zinberg, 1984).

However, the idea that individuals are pressurised by their position in the social structure to stray from paths of convention and indulge in 'deviant' behaviour is seen by some (see for example Matza, 1964) as being overly deterministic in that it implies that people are controlled by external forces and have little or no freedom to direct their own actions, thus ignoring the issue of 'agency' and the choices and alternatives which are available for human action. Given the findings of this study though, such views indicate a lack of understanding of the dynamic nature of spatially situated social exclusion, and a disregard for the constricted choices and opportunities open to people located both at the lower end of the class structure and in particular neighbourhoods.

However, it is important to note that the labelling and definition of deviant behaviour is linked into the wider power relations and the dominant ideological paradigms of society. The findings of this study suggest that rather than designating the heroin users as 'deviants', it may be more realistic to view them as people who subscribe to an irregular work ethic in an illicit market, proceeding as best they can with limited social and economic capital.

In the heroin neighbourhoods in Dublin, we saw how the mass of young people 'hanging around' out of school and out of work provided the context for 'deviant behaviour' – in this case drug use and involvement in the informal economy. The return for those involved, leastways for a time, was status and the goods and/or

monetary means to buy into a heavily-branded youth lifestyle. Indeed, throughout the interviews, presenting an image based on having the right branded clothes and accessories was consistently raised as an important aspect of the interviewees' lives. This suggests that the heroin users may indeed be akin to Merton's (1957) 'innovators' in that they have internalised the value of success and sought to achieve *inter alia* status and success through their heroin career, albeit by what Merton termed 'deviant' means.

This interpretation of the evidence does not necessarily imply the existence of a subculture - a collective response with norms and values different to those held by other members of society. An alternative view, such as that proposed by Hannerz (1969) is that they are 'situationally adaptive' to the structural conditions imposed on them and that their response is merely the adaptation of means to achieve culturally feasible ends. Indeed, the values and attitudes expressed by the heroin users, for the most part reflect the values and attitudes of the mainstream - the desire for status, monetary reward, and branded goods. In the absence of legitimate means, rather than as viewed by Murray (1990) implying their having a different value system, they seem to have a surfeit of mainstream values and a deep desire to compensate for their poverty and lack of status through the conspicuous consumption of social goods (cf Nightingale 1993; Bourgois, 1995; Young, 1999).

Policy implications

Deconstructing concepts of 'deviancy' and 'values' associated with heroin users is key to improving policy responses to both drug problems and social exclusion. For example, the social construction of a 'junkie', and the process of defining and labelling what is junkie behaviour, was seen to affect the type of drug treatment available to the heroin users in terms of the surveillance and control exercised over them. The irony of this is that the nature of treatment regimes on offer returned the heroin users to the powerless state which prompted them to take up a heroin career in the first instance. As a result, this type of treatment seemed almost inevitably to fail.

Broadening our understanding and analysis of the lived experience of heroin use and social exclusion may serve to inform policy-making and, as MacGregor (2003)

suggests, shift its focus from the shortcomings of individuals to the shortcomings of the socio-economic system which engendered them. In this sense, if risk environments for problem drug use are to be addressed a broad spectrum of social policies relating to housing, unemployment, education and welfare are required, in conjunction with a will to combat the inequities embedded in our socio-economic system.

Postscript

The fieldwork for this study was conducted between 1996 and 1998. Over the years and with the exigencies of full-time work, the analysis and writing of this research study was reduced to an intermittent activity. In the interim, I came to work and now live in one of the neighbourhoods I had included in this study. Doing so, I believe, has facilitated the analysis of this work, as my ongoing contact with heroin users and those who work with them contributed to a more sophisticated analysis and understanding of the complex dynamics in excluded neighbourhoods.

Whether much has changed since the fieldwork was conducted is a moot question. Ireland was both entering an economic boom and reaching the peak of a heroin epidemic at the time I began this study. This boom has created material wealth that was almost unimaginable as little as ten years ago. However, the benefits accrued by the socially excluded have been slight in comparison. In the neighbourhoods studied in the research, more people are now working, there is more disposable income and more material trappings and a number of the neighbourhoods are in the process of regeneration, yet there has been little change to the underlying structural and social conditions. A recent EU report on *The social situation in the European Union* (2004)¹⁷ shows that Ireland ranks among the member states with the greatest gap between rich and poor, and that more than one fifth of Irish citizens are at risk of poverty.

The heroin epidemic may have peaked but drug careers continue to develop in the excluded neighbourhoods. Drug treatment services have expanded in numbers and

¹⁷ Cited in report by Honor Mahony, 'Ireland's gap between rich and poor among widest in EU', *The Irish Times*, Saturday 2 October 2004, p1.

improved in quality, yet demand for treatment continues to be higher than supply. Heroin is no longer the predominant drug of choice for a drug career; cocaine has arrived in the neighbourhoods adding an edgy paranoia to the atmosphere, and poly-drug use particularly with benzodiazepines has become the centrepiece of the problem drug users's repertoire.

My home looks out on one of the flat complexes which featured in this study, and as I write this I keep a watchful eye on activities across the way. The block nearest to me has been emptied awaiting demolition, and while the doors and windows had been boarded up, the hoardings have since been torn down to provide a safe haven for the local drugs market. People come and go throughout the day and night, and walking by the blocks the drug-related detritus of burnt out cans and syringes are plain to see.

Plus ça change, plus la même chose

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¹⁸ In order to maintain some element of anonymity for the five neighbourhoods studied in this thesis, in the text I have used the acronym for the authors' names where they identify the areas concerned. In the bibliography, the relevant titles are listed by the acronym used in the text and the authors' full name is given in brackets for reference purposes.

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Appendix 1: Glossary

| | |
|----------------------|--|
| acid | LSD |
| bag | a bag of heroin, the standard retail unit, also called a Q/quarter |
| bang | inject |
| banged up | imprisoned |
| barrell | part of syringe |
| batches | package with 16-18 bags of heroin |
| benzos | benzodiazepines – sedatives, tranquillisers, anti-depressants |
| bird | woman |
| blanked | ignored |
| blow | drug |
| buzz | 'high' |
| celtic tiger | name given to 1990s economic boom in Ireland |
| charges | criminal charges |
| chasing (the dragon) | smoking heroin using a tooter to inhale fumes of heated drug |
| claim | insurance claim |
| cold turkey | stop using heroin without treatment |
| copper | garda/police |
| culchie | person from rural area |
| dabbling | taking drug occasionally |
| detox(ification) | planned withdrawal from drug |
| DEDs | District Electoral Divisions |
| E | ecstasy |
| fella | boyfriend |
| fix | inject |
| foil | tin foil commonly used to hold heroin powder while heating |
| gaff | house/home |
| gear | heroin |
| Garda Síochana | Irish police force |
| hash | cannabis |
| high | effect of drug |
| HLOs | Home Liaison officers (school) |
| hop (on the) | skipping school |
| Inter Cert. | intermediate certificate examination taken in second level school |
| IV | intravenous drug use – injecting into a vein |
| JLOs | Junior Liaison Officers (police) |
| joy riding | driving stolen cars |
| jump over | shop robbery |
| kip | dump |
| labour | dole/ receiving unemployment benefit |
| Leaving Cert. | examination taken when leaving second level school |

| | |
|------------------|---|
| mainlining | injecting into the vein |
| maintenance | ongoing methadone treatment |
| methadone | pharmaceutical opiate used to treat drug dependency |
| microdots | LSD |
| MSTs | morphine sulphate (opiate) tablets |
| Napps | MSTs/opiate tablets |
| needle | syringe for injecting drug |
| opiate | narcotic drug (often synthetic) derived from opium |
| ould fellas | men |
| ould ones | women |
| Phy/Physeptone | brand of Methadone (see above) |
| Qs | quantity of heroin (see 'bag' above) |
| rattling | nervous, scared |
| rehab | rehabilitation treatment |
| rips | fakes |
| Roche | Valium/diazepam tablets |
| Rohypnol | pharmaceutical sedative |
| runners | sneakers |
| scarlet | embarrassed |
| score | buy drugs |
| score, a | twenty pounds |
| scratcher | dole/unemployment benefit |
| script | prescription for drugs |
| sickness | withdrawal symptoms when effects of heroin waning |
| skin popping | injecting into flesh, not vein |
| skins | cigarette papers |
| speed | amphetamine |
| spike | needle |
| stoned | effect of drug |
| strap (on) | on credit |
| stroke | rob |
| strung out | addicted to heroin |
| tabs | LSD |
| turn on | inject - as in "I had a turn on", "he gave me a turn on" |
| tooter | hollow tube used to inhale fumes of drugs |
| town | central areas of Dublin city as distinct from the suburbs |
| urine/urinalysis | give a urine - for analysis |
| used/using | injected/injecting |
| vigies | vigilantes |
| virus | HIV virus |
| warrants | for arrest |
| wired | manic |
| withdrawls | symptoms experienced when stop using drug |
| works | syringe/equipment used for injecting drug |
| young wans/ones | girls |

Appendix 2: Interview Aide Memoire

Introduction: aim of research - methods - confidentiality - request to tape

Personal data

Area residence– DOB- Gender

Neighbourhood

Description of area

Facilities in area

Comparison with other areas

Drug availability in area

Family

Home - describe people & place

Relationship with parents/other family members

Parents occupation/financial situation

Current living status: partner/family of origin etc.

Children

Education

Experience at school

Age left/Exams taken

Further Education

Employment

Type and availability of work locally

Training received

Work history - ever worked

Other family members/peers occupation

Lifestyle

Typical daily activities

General interests

Future ambitions

Social networks

Drug use history

Initial Use (+ alcohol/tobacco)

What, how and why taken

With whom - age - where taken

How accessed: offered/sought

How knew what/how to take

Prior knowledge of effects

Actual effect - pleasurable/problematic

Social Consequences of drug use

Contact with police/JLOs

(criminal record/ probation/prison)

Money problems/debt

Dropped out: school/training/job

Relationships: parent/partner/kids

Family/partner/kids knowledge of use

Changes in lifestyle/social networks

Contact with Anti-drugs movement

Patterns of Use (note changes over time)

Drugs used - Drug of choice

Mode of administration/self administered

Drug using network: age/gender

Family members/Partner taking drugs

Drug taking rituals

Typical amount consumed per day/week

Ability to control use/rationing strategies

Typical daily/weekly expenditure on drugs

Financial sources

Relationship with dealer/involvement in dealing

Health Consequences of drug use

Overdose

Injecting history & practice

Needle sharing: lend/borrow- pass on /receive - needle/barrel/works

Harm reduction techniques

Aware/concern re HIV/Hepatitis

Impact on drug use - sexual behaviour

Condom use: always/never/sometimes

HIV - HVB - HVC status

Treatment/Giving Up

Ever considered giving up - Ever sought help

Length of time from first used drug, to recognising problem, to seeking help, to receiving help?

Ever tried giving up: Self managed/G P involvement/Treatment Centre

Affect of treatment/giving up on lifestyle

Appendix 3: Ethnograph Codebook

| CODEWORD | DEFINITION |
|-----------|--|
| # USE | Cannabis/Hash Use. Evidence of normalisation. |
| 1ST USE | Initial use, what was the context of the first time trying the drug, who were they with, where, how did they get hold of it etc. Dabbling. First time with any drug. |
| ACS | ACCESS to supplier, dealer, opportunity to use, places, works, how knew where to get etc. |
| ADMIN | Mode of Administration of the drug. Smoking v injecting, why moved from one to the other. |
| ALCOHL | Alcohol use, problems, mix with drugs. |
| CNTRL | Drug Control - experience of rationing and controlling use, smoking v injecting etc. |
| COM ACT | Community Action, from anti drug campaigns to local help |
| CRIME | Involvement in crime, both drug related and non, involvement with criminal justice system, probation, jlos etc. |
| DEALG | experience of dealing, description of networks, money involved etc. |
| DEV USE | Development of use - how moved from one drug to another, from small amounts to larger, from smoking to injecting, learning to be stoned etc. |
| DRGAWARE | Awareness, knowledge about drugs and their effects, if they could get addicted |
| DRGCST | Drug Cost - how much drug use was costing, how financed etc. |
| DRGDURATN | Length of time using drug. |
| DRGEFCT | EFFECTS - Actual effect of drug. Did the use of drug give a high, low, sick feeling. What was the buzz. |
| DRGNET | NETWORKS - Drug using friends, gang etc. What has become of them. Status. Drug culture. |
| DRGRITUAL | Drug using rituals. Stories, descriptions about injecting, smoking, getting a hit, doing the business etc. Drug using career. |
| DRGUSE | DRUG USE - Primary/Main drug of use (should mainly be opiates) used, how often, how much, patterns. |
| DRGVW | Drug View - Views of drug use, drug users, drug scene, not proper junkies, 'labour day junkies' etc. Belief able to handle drug, couldn't happen to me etc. |
| E | Ecstasy use, rave scene etc. |
| E&H | Link between Ecstasy and gear |
| ED | Education - level of education reached, qualifications received, age left school, perceptions of ed. |
| EMPLOY | Employment - Experience of working, training etc. |

| | |
|------------------------|--|
| FAMEFCT | EFFECTS - Family Effect - effect drug use and behavioural changes have had on their parental family |
| FAMPAR | PARENTFAMY - Parental family Home - description of place, where etc. and characters within, other drug users |
| FAMRELAT | PARENTFAMY - Parental family relationships - how they get on with their parental family, how they're perceived, what they do for each other, how they interact |
| FFAWARE | Friends and families awareness, knowledge and perceptions of drugs and what was going on. |
| GUP | GIVING UP - Experience of attempts to give up using and views about doing so |
| HELP | Who helped and how, who didnt help, how they were treated by organisations, professionals etc. |
| HLTH EFCT | EFFECTS - Health Effects. Physical etc. effects of using the drug e.g. weight, Hep B/C, HIV, ODing, Death. |
| HME-OWN | OWN FAMILY - where lived, not parental, conditions, dynamics, homeless etc. |
| IVW | Dynamics of interview, view of respondent. |
| KIDS | OWN FAMILY - description of kids, treatment of them etc. |
| L'STyle | Lifestyle - general activities, way of live, how they spent their day, any hobbies, where hanging around,etc. Experience of homelessness. |
| N'HD | Local neighbourhood, description, things to do in the area, where hung out, what got up to etc. |
| OTH DRG | Other drug use aside from E, #, opiates, e.g. acid, cocaine, crack. Secondary drugs. |
| P&P | Price and Purity |
| PERSEFCT | EFFECTS - Personal effect - how drug use has affected their personality, looks, relationships, invlovement in theft, general behavioural changes etc. |
| PERSPROBS | Personal problems other than drug taking e.g. death of family, friend member, poverty, coping with kids, homelessness etc. |
| PRISON | CRIME - Experience of Prison/detention centres etc. esp. drug use their and how they were Treated personally and for their habit |
| PROB USE | PROBLEMS Signs, awareness of being strung out, addicted |
| PROSTITUTN | Involvement in prostitution, on the game etc. esp. if financing drug habit. |
| PRTNR | OWN FAMILY - Description of partner(s) and life with them, how they interacted, behaved etc. |
| PRTNR USE RISK B/RB | Partner's use of drugs Risk behaviour, injecting practices and hygiene, Oding, safe sex etc. esp. re. preventing catching Viruses. |
| SELF | Clues, description of personality, behavioural traits |
| SEXUAL BEH | Sexual Behaviour, No. of partners etc. |

| | |
|----------|---|
| SICK | PROBLEM - Experience and perceptions of "the sickness", cold turkey etc. i.e. the effects of being addicted to heroin. Learning to be sick. |
| SOC NET | NETWORKS - Social networks - friends, family etc. not necessarily drug networks, their reaction to drug use, drink and 'soft drugs' |
| TREAT | TREATMENT - where treated, how often, by whom, what sort of treatment, view of treatment |
| VIOLENCE | Experience of violence, Own violent behaviour |
| WHY DRGS | DUs explanations/justifications for why they use drugs. Examples of saying would never touch it. |
| WOMEN | Issues relating to women and drug use |

Appendix 4: Area Data Tables

Table 4.1: Demographic Data

| Area ¹⁸ | DED ID No. ¹⁹ | N. Population | Density ²⁰ | Pop. Aged 15-29 (%) | Pop. change 1986-1996 | N. Households | Lone parents (% of all households) ²¹ |
|----------------------|--------------------------|---------------|-----------------------|---------------------|-----------------------|---------------|--|
| Westown | 3008 | 6 697 | 8 022 | 27.9% | 9.5% | 1 742 | 11.5% |
| | 3009 | 5 238 | 19 006 | 31.7% | - 6.5% | 1 240 | 19.8% |
| | 3020 | 8 449 | 5 583 | 26.1% | 22.0% | 2 070 | 11.4% |
| Talltown | 2016 | 4 431 | 17 100 | 31.0% | - 11.8% | 1 317 | 27.3% |
| | 2017 | 6 575 | 21 808 | 30.3% | - 11.2% | 2 022 | 27.4% |
| | 2018 | 3 794 | 20 880 | 28.5% | - 5.2% | 1 322 | 32.3% |
| Eastown | 2081 | 3 353 | 18 289 | 30.9% | - 7.4% | 704 | 20.7% |
| | 2082 | 3 790 | 10 794 | 26.6% | - 8.1% | 914 | 33.2% |
| Northtown | 2073 | 3 108 | 27 028 | 30.1% | - 3.5% | 1 079 | 28.5% |
| | 2074 | 1 994 | 23 182 | 40.2% | 21.5% | 964 | 12.7% |
| Southtown | 2155 | 1 802 | 31 765 | 29.4% | - 4.4% | 777 | 18.8% |
| | 2156 | 1 894 | 21 931 | 25.2% | - 5.3% | 807 | 22.8% |
| Dublin Region | | 1 058 264 | 2 983 | 27.4% | 3.6% | 344 264 | 10.8% |

Source: 1996 Census

¹⁸ The names of the areas investigated for this study have been changed to provide anonymity and avoid further stigmatisation for the residents of the neighbourhood.

¹⁹ I have retained the identification number of the District Electoral Divisions (DEDs) which constitute the neighbourhood for purposes of verification.

²⁰ Density = number of persons per square mile.

²¹ Total number of households consisting of a single male or female parent with children of any age, expressed as a percentage of all families (single parents and couples).

Table 4.2: Education Data

| Area | DED ID Number | Pop. no formal or primary education only (%) | Age education ceased < =15 (%) ²² | Pop. 3rd level education (%) |
|----------------------|---------------|--|--|------------------------------|
| Westtown | 3008 | 34.0% | 49.5% | 7.1% |
| | 3009 | 42.8% | 57.3% | 3.5% |
| | 3020 | 30.8% | 36.2% | 15.3% |
| Easttown | 2081 | 49.6% | 61.1% | 2.3% |
| | 2082 | 41.6% | 60.3% | 2.8% |
| Talltown | 2016 | 49.4% | 58.7% | 3.4% |
| | 2017 | 43.1% | 54.2% | 5.1% |
| | 2018 | 39.2% | 59.4% | 3.9% |
| Northtown | 2073 | 50.9% | 72.1% | 10.1% |
| | 2074 | 41.4% | 48.2% | 19.5% |
| Southtown | 2155 | 44.3% | 51.3% | 15.0% |
| | 2156 | 39.6% | 48.4% | 15.6% |
| Dublin Region | | 25.0% | 48.9% | 25.4% |

Source: 1996 Census

²² As a percentage of total persons whose full time education has ceased excluding the not stated category.

Table 4.3: Overall Employment Data and Male Employment Data

| Area | DED ID Number | Pop. At work ²³ | Unemployment rate ²⁴ | Male Unemployment rate | Males unemployed 3 years+ (%) ²⁵ | Female Unemployment rate | Females in part time work (%) |
|----------------------|---------------|----------------------------|---------------------------------|------------------------|---|--------------------------|-------------------------------|
| Westown | 3008 | 46.3% | 28.9% | 31.8% | 51.4% | 24.2% | 34.8% |
| | 3009 | 39.4% | 36.8% | 41.1% | 55.0% | 29.5% | 42.7% |
| | 3020 | 47.5% | 21.1% | 24.5% | 58.6% | 15.8% | 32.8% |
| Eastown | 2081 | 33.0% | 46.2% | 52.6% | 60.1% | 35.7% | 50.5% |
| | 2082 | 29.0% | 51.2% | 55.7% | 66.1% | 43.9% | 51.2% |
| Talltown | 2016 | 34.9% | 43.8% | 47.5% | 63.6% | 38.3% | 40.1% |
| | 2017 | 35.2% | 42.1% | 45.9% | 60.1% | 37.1% | 41.7% |
| | 2018 | 30.7% | 41.9% | 51.0% | 62.2% | 29.4% | 49.2% |
| Northtown | 2073 | 24.1% | 59.0% | 63.1% | 72.4% | 53.3% | 25.5% |
| | 2074 | 33.9% | 47.4% | 49.8% | 51.7% | 43.5% | 22.8% |
| Southtown | 2155 | 37.4% | 37.6% | 41.1% | 64.1% | 33.3% | 29.0% |
| | 2156 | 33.0% | 42.4% | 44.9% | 72.6% | 39.2% | 27.6% |
| Dublin Region | | 49.6% | 15.5% | 17.6% | 54.2% | 12.5% | 25.4% |

Source: 1996 Census

²³ Percentage of population aged 15 plus at work.

²⁴ Sum of those unemployed and First Job Seekers expressed as a percentage of the labour force i.e. those At Work, First Job Seekers and the Unemployed.

²⁵ Percentage of unemployed males aged 15 years and over, excluding the not stated category, who have been unemployed for more than 3 years.

Table 4.4: Social Class Data

| Area | DED ID Number | Social class 1 ²⁶ | Social class 5 ²⁷ | Social class 6 ²⁸ | Social class 7 ²⁹ |
|---------------|---------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Westtown | 3008 | 1.0% | 18.5% | 11.7% | 13.1% |
| | 3009 | 0.4% | 22.3% | 15.2% | 14.2% |
| | 3020 | 2.0% | 14.8% | 8.9% | 16.8% |
| Easttown | 2081 | 0.5% | 22.2% | 17.4% | 19.8% |
| | 2082 | 0.2% | 20.9% | 14.3% | 33.0% |
| Talltown | 2016 | 0.6% | 20.0% | 13.4% | 30.5% |
| | 2017 | 1.0% | 16.6% | 12.5% | 32.7% |
| | 2018 | 0.5% | 16.9% | 10.3% | 40.5% |
| Northtown | 2073 | 1.3% | 12.8% | 16.1% | 45.6% |
| | 2074 | 3.5% | 12.7% | 11.8% | 39.9% |
| Southtown | 2155 | 2.4% | 19.0% | 9.5% | 24.1% |
| | 2156 | 3.4% | 16.3% | 13.6% | 20.6% |
| Dublin Region | | 6.9% | 11.7% | 6.4% | 13.1% |

Source: 1996 Census

²⁶ Professional Workers.

²⁷ Semiskilled manual workers.

²⁸ Unskilled manual workers.

²⁹ Unclassified, this includes those who have never been in paid employment or who live in households where the head of the household has never been in paid employment.

Table 4.5: Average Household Expenditure

| Area | DED ID Number | Average total weekly household expenditure (IR£) ³⁰ |
|----------------------|---------------|--|
| Westtown | 3008 | 280 |
| | 3009 | 260 |
| | 3020 | 305 |
| Easttown | 2081 | 247 |
| | 2082 | 233 |
| Talltown | 2016 | 240 |
| | 2017 | 246 |
| | 2018 | 234 |
| Northtown | 2073 | 231 |
| | 2074 | 253 |
| Southtown | 2155 | 278 |
| | 2156 | 274 |
| Dublin Region | | 323 |

Source: ESRI Household Budget Survey 1994

³⁰ Estimated from ESRI Household Budget Survey 1994

Appendix 5: Interview Sample, Data Tables

Table 5.1: Gender of interviewees

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|--------|-----------|---------|---------------|--------------------|
| Valid | Male | 34 | 55.7 | 55.7 | 55.7 |
| | Female | 27 | 44.3 | 44.3 | 100.0 |
| | Total | 61 | 100.0 | 100.0 | |

Table 5.2: Age of interviewees

| | | |
|---------|---------|-------|
| N | Valid | 61 |
| | Missing | 0 |
| Mean | | 24.02 |
| Median | | 23.00 |
| Mode | | 19 |
| Range | | 28 |
| Minimum | | 15 |
| Maximum | | 43 |

Table 5.3: Age range of interviewees by Gender of interviewee

| | | | Gender of interviewee | | Total |
|---------------------------|-------|------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Age range of interviewees | 15-19 | Count | 11 | 6 | 17 |
| | | % of Total | 18.0% | 9.8% | 27.9% |
| | 20-24 | Count | 7 | 14 | 21 |
| | | % of Total | 11.5% | 23.0% | 34.4% |
| | 25-29 | Count | 9 | 4 | 13 |
| | | % of Total | 14.8% | 6.6% | 21.3% |
| | 30-34 | Count | 5 | 1 | 6 |
| | | % of Total | 8.2% | 1.6% | 9.8% |
| | 35-39 | Count | 1 | 1 | 2 |
| | | % of Total | 1.6% | 1.6% | 3.3% |
| | 40-44 | Count | 1 | 1 | 2 |
| | | % of Total | 1.6% | 1.6% | 3.3% |
| | Total | Count | 34 | 27 | 61 |
| | | % of Total | 55.7% | 44.3% | 100.0% |

Table 5.4: Area of residence by Gender of interviewee

| | | | Gender of interviewee | | Total |
|-------------------|----------------------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Area of Residence | Easttown | Count | 6 | 5 | 11 |
| | | % within Area of Residence | 54.5% | 45.5% | 100.0% |
| | | % of Total | 9.8% | 8.2% | 18.0% |
| | Northtown | Count | 8 | 6 | 14 |
| | | % within Area of Residence | 57.1% | 42.9% | 100.0% |
| | | % of Total | 13.1% | 9.8% | 23.0% |
| | Southtown | Count | 6 | 5 | 11 |
| | | % within Area of Residence | 54.5% | 45.5% | 100.0% |
| | | % of Total | 9.8% | 8.2% | 18.0% |
| | Talltown | Count | 7 | 5 | 12 |
| | | % within Area of Residence | 58.3% | 41.7% | 100.0% |
| | | % of Total | 11.5% | 8.2% | 19.7% |
| | Westtown | Count | 7 | 6 | 13 |
| | | % within Area of Residence | 53.8% | 46.2% | 100.0% |
| | | % of Total | 11.5% | 9.8% | 21.3% |
| Total | Count | 34 | 27 | 61 | |
| | % within Area of Residence | 55.7% | 44.3% | 100.0% | |
| | % of Total | 55.7% | 44.3% | 100.0% | |

Table 5.5: Age Left School

| | | |
|---------|---------|-------|
| N | Valid | 52 |
| | Missing | 9 |
| Mean | | 14.62 |
| Median | | 15.00 |
| Mode | | 15 |
| Range | | 6 |
| Minimum | | 11 |
| Maximum | | 17 |

Table 5.6: Age left School by Gender of interviewee

| | | Gender of interviewee | | Total |
|----------|---------|-----------------------|--------|-------|
| | | Male | Female | |
| Age left | <15 | 11 | 11 | 22 |
| School 2 | 15 | 10 | 7 | 17 |
| | 16+ | 8 | 5 | 13 |
| | Missing | 5 | 4 | 9 |
| Total | | 34 | 27 | 61 |

Table 5.7: Main drug of use by Gender of interviewee

| | | | Gender of interviewee | | Total |
|------------------|----------------------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Main drug of use | Heroin | Count | 24 | 20 | 44 |
| | | % of Gender of interviewee | 70.6% | 74.1% | 72.1% |
| | | % of Total | 39.3% | 32.8% | 72.1% |
| | Polydrug | Count | 10 | 7 | 17 |
| | | % of Gender of interviewee | 29.4% | 25.9% | 27.9% |
| | | % of Total | 16.4% | 11.5% | 27.9% |
| Total | Count | | 34 | 27 | 61 |
| | % of Gender of interviewee | | 100.0% | 100.0% | 100.0% |
| | % of Total | | 55.7% | 44.3% | 100.0% |

Table 5.8: Main mode of use by Gender of interviewee

| | | | Gender of interviewee | | Total |
|------------------|---------------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Main mode of use | Inject | Count | 25 | 19 | 44 |
| | | % of Gender of interviewee | 73.5% | 70.4% | 72.1% |
| | | % of Total | 41.0% | 31.1% | 72.1% |
| | smoke | Count | 7 | 6 | 13 |
| | | % of Gender of interviewee | 20.6% | 22.2% | 21.3% |
| | | % of Total | 11.5% | 9.8% | 21.3% |
| | ingest | Count | 1 | 1 | 2 |
| | | % of Gender of interviewee | 2.9% | 3.7% | 3.3% |
| | | % of Total | 1.6% | 1.6% | 3.3% |
| | snort | Count | 0 | 1 | 1 |
| | | % of Gender of interviewee | .0% | 3.7% | 1.6% |
| | | % of Total | .0% | 1.6% | 1.6% |
| | drink ³¹ | Count | 1 | 0 | 1 |
| | | % of Gender of interviewee | 2.9% | .0% | 1.6% |
| | | % of Total | 1.6% | .0% | 1.6% |
| Total | | Count | 34 | 27 | 61 |
| | | % of Gender of interviewee | 100.0% | 100.0% | 100.0% |
| | | % of Total | 55.7% | 44.3% | 100.0% |

³¹ Methadone

Table 5.9: Ever Injected by Gender of interviewee

| | | | Gender of interviewee | | Total |
|---------------|-------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Ever Injected | Yes | Count | 29 | 24 | 53 |
| | | % of Ever Injected | 54.7% | 45.3% | 100.0% |
| | | % of Gender of interviewee | 85.3% | 88.9% | 86.9% |
| | | % of Total | 47.5% | 39.3% | 86.9% |
| | No | Count | 5 | 3 | 8 |
| | | % of Ever Injected | 62.5% | 37.5% | 100.0% |
| | | % of Gender of interviewee | 14.7% | 11.1% | 13.1% |
| | | % of Total | 8.2% | 4.9% | 13.1% |
| | Total | Count | 34 | 27 | 61 |
| | | % of Ever Injected | 55.7% | 44.3% | 100.0% |
| | | % of Gender of interviewee | 100.0% | 100.0% | 100.0% |
| | | % of Total | 55.7% | 44.3% | 100.0% |

Table 5.10: Mode of first use by Gender of interviewee

| | | | Gender of interviewee | | Total |
|-------------------|----------------------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Mode of first use | Inject | Count | 8 | 4 | 12 |
| | | % of Gender of interviewee | 24.2% | 14.8% | 20.0% |
| | | % of Total | 13.3% | 6.7% | 20.0% |
| | smoke | Count | 21 | 20 | 41 |
| | | % of Gender of interviewee | 63.6% | 74.1% | 68.3% |
| | | % of Total | 35.0% | 33.3% | 68.3% |
| | ingest | Count | 3 | 1 | 4 |
| | | % of Gender of interviewee | 9.1% | 3.7% | 6.7% |
| | | % of Total | 5.0% | 1.7% | 6.7% |
| | Snort | Count | 0 | 2 | 2 |
| | | % of Gender of interviewee | .0% | 7.4% | 3.3% |
| | | % of Total | .0% | 3.3% | 3.3% |
| | Drink ³² | Count | 1 | 0 | 1 |
| | | % of Gender of interviewee | 3.0% | .0% | 1.7% |
| | | % of Total | 1.7% | .0% | 1.7% |
| Total | Count | | 33 | 27 | 60 |
| | % of Gender of interviewee | | 100.0% | 100.0% | 100.0% |
| | % of Total | | 55.0% | 45.0% | 100.0% |

³² Methadone

Table 5.11: Main mode of use by Mode of first use

| | | | Mode of first use | | | | | Total |
|------------------|------------------------|------------------------|-------------------|--------|--------|--------|---------------------|--------|
| | | | inject | smoke | ingest | snort | drink ³³ | |
| Main mode of use | inject | Count | 11 | 29 | 2 | 1 | 0 | 43 |
| | | % of Main mode of use | 25.6% | 67.4% | 4.7% | 2.3% | .0% | 100.0% |
| | | % of Mode of first use | 91.7% | 70.7% | 50.0% | 50.0% | .0% | 71.7% |
| | | % of Total | 18.3% | 48.3% | 3.3% | 1.7% | .0% | 71.7% |
| | smoke | Count | 1 | 12 | 0 | 0 | 0 | 13 |
| | | % of Main mode of use | 7.7% | 92.3% | .0% | .0% | .0% | 100.0% |
| | | % of Mode of first use | 8.3% | 29.3% | .0% | .0% | .0% | 21.7% |
| | | % of Total | 1.7% | 20.0% | .0% | .0% | .0% | 21.7% |
| | ingest | Count | 0 | 0 | 2 | 0 | 0 | 2 |
| | | % of Main mode of use | .0% | .0% | 100.0% | .0% | .0% | 100.0% |
| | | % of Mode of first use | .0% | .0% | 50.0% | .0% | .0% | 3.3% |
| | | % of Total | .0% | .0% | 3.3% | .0% | .0% | 3.3% |
| | snort | Count | 0 | 0 | 0 | 1 | 0 | 1 |
| | | % of Main mode of use | .0% | .0% | .0% | 100.0% | .0% | 100.0% |
| | | % of Mode of first use | .0% | .0% | .0% | 50.0% | .0% | 1.7% |
| | | % of Total | .0% | .0% | .0% | 1.7% | .0% | 1.7% |
| | drink ³⁴ | Count | 0 | 0 | 0 | 0 | 1 | 1 |
| | | % of Main mode of use | .0% | .0% | .0% | .0% | 100.0% | 100.0% |
| | | % of Mode of first use | .0% | .0% | .0% | .0% | 100.0% | 1.7% |
| | | % of Total | .0% | .0% | .0% | .0% | 1.7% | 1.7% |
| Total | Count | | 12 | 41 | 4 | 2 | 1 | 60 |
| | % of Main mode of use | | 20.0% | 68.3% | 6.7% | 3.3% | 1.7% | 100.0% |
| | % of Mode of first use | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | % of Total | | 20.0% | 68.3% | 6.7% | 3.3% | 1.7% | 100.0% |

³³ Methadone

³⁴ Methadone

Table 5.12: Age of first use

| | | |
|---------|---------|-------|
| N | Valid | 60 |
| | Missing | 1 |
| Mean | | 17.80 |
| Median | | 17.00 |
| Mode | | 16 |
| Range | | 20 |
| Minimum | | 13 |
| Maximum | | 33 |

**Table 5.13: Age range of first use of drug
by Gender of interviewee**

| | | Gender of interviewee | | Total |
|---------------------|---------|-----------------------|--------|-------|
| | | Male | Female | |
| Age of first use | <15 | 4 | 6 | 10 |
| | 15-17 | 16 | 8 | 24 |
| | 18 | 3 | 3 | 6 |
| | 19-21 | 6 | 5 | 11 |
| | 22+ | 4 | 5 | 9 |
| | Missing | 1 | 0 | 1 |
| Total | | 34 | 27 | 61 |

Table 5.14: Difference in age left school and age first used main drug

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---------|----------------|-----------|---------|---------------|--------------------|
| Valid | -2 | 1 | 1.6 | 1.9 | 1.9 |
| | -1 | 2 | 3.3 | 3.8 | 5.8 |
| | 0 | 10 | 16.4 | 19.2 | 25.0 |
| | 1 | 16 | 26.2 | 30.8 | 55.8 |
| | 2 | 3 | 4.9 | 5.8 | 61.5 |
| | 3 | 3 | 4.9 | 5.8 | 67.3 |
| | 4 | 5 | 8.2 | 9.6 | 76.9 |
| | 5 | 5 | 8.2 | 9.6 | 86.5 |
| | 6 | 2 | 3.3 | 3.8 | 90.4 |
| | 7 | 2 | 3.3 | 3.8 | 94.2 |
| | 8 | 1 | 1.6 | 1.9 | 96.2 |
| | 10 | 1 | 1.6 | 1.9 | 98.1 |
| | 14 | 1 | 1.6 | 1.9 | 100.0 |
| | Total | 52 | 85.2 | 100.0 | |
| Missing | System Missing | 9 | 14.8 | | |
| Total | | 61 | 100.0 | | |

Table 5.15: Overall duration of use

| | | |
|---------|---------|------|
| N | Valid | 57 |
| | Missing | 4 |
| Mean | | 4.49 |
| Median | | 4.00 |
| Mode | | 2 |
| Range | | 14 |
| Minimum | | 1 |
| Maximum | | 15 |

Table 5.16: Number of children by Gender of interviewee

| | | | Gender of interviewee | | Total |
|----------------|----------------------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Number of kids | 0 | Count | 21 | 11 | 32 |
| | | % of Gender of interviewee | 61.8% | 42.3% | 53.3% |
| | | % of Total | 35.0% | 18.3% | 53.3% |
| | 1 | Count | 9 | 6 | 15 |
| | | % of Gender of interviewee | 26.5% | 23.1% | 25.0% |
| | | % of Total | 15.0% | 10.0% | 25.0% |
| | 2 | Count | 2 | 2 | 4 |
| | | % of Gender of interviewee | 5.9% | 7.7% | 6.7% |
| | | % of Total | 3.3% | 3.3% | 6.7% |
| | 3 | Count | 1 | 5 | 6 |
| | | % of Gender of interviewee | 2.9% | 19.2% | 10.0% |
| | | % of Total | 1.7% | 8.3% | 10.0% |
| | 4 | Count | 1 | 1 | 2 |
| | | % of Gender of interviewee | 2.9% | 3.8% | 3.3% |
| | | % of Total | 1.7% | 1.7% | 3.3% |
| | 5 | Count | 0 | 1 | 1 |
| | | % of Gender of interviewee | .0% | 3.8% | 1.7% |
| | | % of Total | .0% | 1.7% | 1.7% |
| Total | Count | | 34 | 26 | 60 |
| | % of Gender of interviewee | | 100.0% | 100.0% | 100.0% |
| | % of Total | | 56.7% | 43.3% | 100.0% |

Table 5.17: Drug using partner by Gender of interviewee

| | | | Gender of interviewee | | Total |
|-------------------|----------------------------|----------------------------|-----------------------|--------|-------|
| | | | Male | Female | |
| Partner drug user | Yes | Count | 12 | 19 | 31 |
| | | % of Gender of interviewee | 36.4% | 73.1% | 52.5% |
| | | % of Total | 20.3% | 32.2% | 52.5% |
| | No | Count | 9 | 2 | 11 |
| | | % of Gender of interviewee | 27.3% | 7.7% | 18.6% |
| | | % of Total | 15.3% | 3.4% | 18.6% |
| | No partner | Count | 12 | 5 | 17 |
| | | % of Gender of interviewee | 36.4% | 19.2% | 28.8% |
| | | % of Total | 20.3% | 8.5% | 28.8% |
| Total | Count | 33 | 26 | 59 | |
| | % of Gender of interviewee | 100.0% | 100.0% | 100.0% | |
| | % of Total | 55.9% | 44.1% | 100.0% | |

Table 5.18: Drug use in family by Gender of interviewee

| | | | Gender of interviewee | | Total | |
|-----------------------|------------|-----------------------|-----------------------|--------|-------|----|
| | | | Male | Female | | |
| Drug use in family | Yes | Count | 21 | 20 | 41 | |
| | | % of | | | | |
| | | Gender of interviewee | 61.8% | 74.1% | 67.2% | |
| | No | % of Total | 34.4% | 32.8% | 67.2% | |
| | | Count | 13 | 7 | 20 | |
| | | % of | | | | |
| | | Gender of interviewee | 38.2% | 25.9% | 32.8% | |
| | | % of Total | 21.3% | 11.5% | 32.8% | |
| | | Total | Count | 34 | 27 | 61 |
| | | | % of | | | |
| Gender of interviewee | 100.0% | | 100.0% | 100.0% | | |
| | % of Total | 55.7% | 44.3% | 100.0% | | |

Table 5.19: Ever treated by Gender of interviewee

| | | | Gender of interviewee | | Total |
|--------------|----------------------------|----------------------------|-----------------------|--------|-------|
| | | | Male | Female | |
| Ever treated | Yes | Count | 32 | 27 | 59 |
| | | % of Gender of interviewee | 94.1% | 100.0% | 96.7% |
| | | % of Total | 52.5% | 44.3% | 96.7% |
| | No | Count | 2 | 0 | 2 |
| | | % of Gender of interviewee | 5.9% | .0% | 3.3% |
| | | % of Total | 3.3% | .0% | 3.3% |
| Total | Count | 34 | 27 | 61 | |
| | % of Gender of interviewee | 100.0% | 100.0% | 100.0% | |
| | % of Total | 55.7% | 44.3% | 100.0% | |

Table 5.20: Currently in treatment by Gender of interviewee

| | | | Gender of interviewee | | Total |
|------------------------|-----|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Currently in treatment | Yes | Count | 23 | 25 | 48 |
| | | % of Gender of interviewee | 67.6% | 92.6% | 78.7% |
| | | % of Total | 37.7% | 41.0% | 78.7% |
| | No | Count | 11 | 2 | 13 |
| | | % of Gender of interviewee | 32.4% | 7.4% | 21.3% |
| | | % of Total | 18.0% | 3.3% | 21.3% |
| Total | | Count | 34 | 27 | 61 |
| | | % of Gender of interviewee | 100.0% | 100.0% | 100.0% |
| | | % of Total | 55.7% | 44.3% | 100.0% |

Table 5.21: Length in treatment by Gender of interviewee

| | | | Gender of interviewee | | Total |
|---------------------|----------------------------|----------------------------|-----------------------|--------|-------|
| | | | Male | Female | |
| Length in treatment | Never treated | Count | 2 | 0 | 2 |
| | | % of Gender of interviewee | 6.1% | .0% | 3.3% |
| | | % of Total | 3.3% | .0% | 3.3% |
| | Not currently in treatment | Count | 9 | 2 | 11 |
| | | % of Gender of interviewee | 27.3% | 7.4% | 18.3% |
| | | % of Total | 15.0% | 3.3% | 18.3% |
| | <3 months | Count | 8 | 12 | 20 |
| | | % of Gender of interviewee | 24.2% | 44.4% | 33.3% |
| | | % of Total | 13.3% | 20.0% | 33.3% |
| | 3-6months | Count | 5 | 7 | 12 |
| | | % of Gender of interviewee | 15.2% | 25.9% | 20.0% |
| | | % of Total | 8.3% | 11.7% | 20.0% |
| | 7-12 months | Count | 4 | 1 | 5 |
| | | % of Gender of interviewee | 12.1% | 3.7% | 8.3% |
| | | % of Total | 6.7% | 1.7% | 8.3% |
| | 1-3 years | Count | 5 | 3 | 8 |
| | | % of Gender of interviewee | 15.2% | 11.1% | 13.3% |
| | | % of Total | 8.3% | 5.0% | 13.3% |
| | 4+ years | Count | 0 | 2 | 2 |
| | | % of Gender of interviewee | .0% | 7.4% | 3.3% |
| | | % of Total | .0% | 3.3% | 3.3% |
| Total | Count | 33 | 27 | 60 | |
| | % of Gender of interviewee | 100.0% | 100.0% | 100.0% | |
| | % of Total | 55.0% | 45.0% | 100.0% | |

Table 5.22: When last used main drug by Gender of interviewee

| | | | Gender of interviewee | | Total |
|----------------|--------------|----------------------------|-----------------------|--------|--------|
| | | | Male | Female | |
| When last used | Current user | Count | 18 | 12 | 30 |
| | | % of Gender of interviewee | 78.3% | 66.7% | 73.2% |
| | | % of Total | 43.9% | 29.3% | 73.2% |
| | <3 months | Count | 2 | 2 | 4 |
| | | % of Gender of interviewee | 8.7% | 11.1% | 9.8% |
| | | % of Total | 4.9% | 4.9% | 9.8% |
| | 3-6months | Count | 1 | 4 | 5 |
| | | % of Gender of interviewee | 4.3% | 22.2% | 12.2% |
| | | % of Total | 2.4% | 9.8% | 12.2% |
| | 7-12 months | Count | 2 | 0 | 2 |
| | | % of Gender of interviewee | 8.7% | .0% | 4.9% |
| | | % of Total | 4.9% | .0% | 4.9% |
| | Total | Count | 23 | 18 | 41 |
| | | % of Gender of interviewee | 100.0% | 100.0% | 100.0% |
| | | % of Total | 56.1% | 43.9% | 100.0% |

Appendix 6: List of individuals and organisations who contributed to the study

The following individuals and organisations contributed to this study as key Informants. The findings of this study do not necessarily reflect their views.

Drs Brion Sweeny, John O'Connor, Shay Keating, National Drug Treatment Centre

Dr Mary Scully, Baggot St Clinic.

Jim and Peggy Cumberton, Tom McGarry, Parents Support Group, Coolmine.

Tony Geoghan; Merchants Quay.

Maugeruite Woods and Ray Byrne, Anna Liffey

Andrew Honeyman, Rutland Centre.

Mary Walsh, Mary Russell, Addiction Counsellors, Dun Laoighaire.

Governor John O'Sullivan and John Sweeney, St Patricks Institution for Young Offenders.

Fearghal Connolly, Community Response.

Liam Collins, Fettercairn Drugs Rehabilitation Programme

Gary Broderick, Ballymun Health Centre.

Derek Shorthall, The Line Projects

Mater Dei Institute

Dr Kieran Harkin, Inchicore and Rialto

Tony Gregory TD

Cathy O'Flaherty, City Clinic

Fergus MacCabe ICON

Liz Richies, Inter Agency Drug Project (IADP)

Michelle Hinds, Veronica Brady Addiction Counsellors, Tallaght

Eilish Fitzpatrick, Addiction Counsellor, Edenmore Health Centre

Jim Lawlor, Rialto Youth Project

Tony MacCarthaigh, Rialto Community Drug Team

Mary Ellen McCann, Ballymun Youth Action Project

Robbie at Carline, Clondalkin

Mick Kelly Joe, Candle Centre Ballyfermot

Shelia Heffernan, Ashling Clinic

Dr Joe Barry, Eastern Health Board

Ellen Gallagher, Talbot Day Centre

Shane Butler, Trinity College Dublin

Dr Jim O'Donoghue, Dublin Counselling and Therapy Centre

Dr Fergus O'Kelly, GP

Chris Murphy, Crosscare

Angela MacLoughlin and colleagues @ Darndale Resource Centre

Gerry McAleenan, SOILSE

Dr Fiona Bradley, Trinity College Dublin

Fr Peter McVerry, Arupe society

Maria McCully, CASP

Aileen Foran, North Wall Womens Centre

Joe Lucy, Crinion Project

Vincent Doherty, Co-ordinator South Inner City Drugs Task Force

Kieran Lenihan, Lourdes Youth and Community Service

Madge Casey, Outreach worker Darndale/Killbarrack

Fettercairn Community Centre